Integrative Health Care:
Defining and Operationalizing the Fundamental Elements
Toronto, November 17-18, 2002

Final Workshop Report

For

Health Policy Research Program, Health Canada

February 28, 2003

Submitted by:
Heather Boon, PhD
Faculty of Pharmacy
University of Toronto
19 Russell Street
Toronto, Ontario
M5S 2S2
Tel. 416-946-5859
Fax. 416-978-1833
Email: heather.boon@utoronto.ca

This workshop was supported by a financial contribution from the Health Policy Research Program, Health Canada (file #6795-15-2001/4430002)

104-03570/

TABLE OF CONTENTS

1. Lay Summary (English)	Page ii
2. Lay Summary (French)	Page iii
3. Executive Summary	Page iv
4. Introduction	Page 1
5. Why is Integration of Complementary and Alternative Health Care a Policy Priority?	Page 1
6. Policy and Program Implications of the Key Findings from the Workshop	Page 2
7. Implementation of the Findings	Page 2
8. Consolidation of Knowledge Gained	Page 3
9. Plans and Prospects for Publication and Dissemination of the Proceedings to Policy Makers	Page 3
10. Summary of the Objectives and Methods of the Workshop	Page 5
Appendix A: Background Paper	Page 12
Appendix B: Agenda from the Workshop	Page 31
Appendix C: Final Report from the Workshop	Page 34
Appendix D: Workshop Participants	Page 44

LAY SUMMARY
Integrative Health Care:
Defining and Operationalizing the Fundamental Elements
Workshop Report
November 17-18, 2002

The increasing use of complementary and alternative health care (CAHC) in North America appears to be leading to a growing integration of CAHC with conventional medicine, at least at the individual consumer level. The widespread use of CAHC and calls for its integration into the Canadian health care system have created an urgent need for policy in this area. Yet it is difficult to make policy decisions given the wide range of perceptions about what constitutes integrative health care. This was the impetus for holding a workshop called "Integrative Health Care: Defining and Operationalizing the Fundamental Elements" with the following objectives:

- to achieve consensus on a working definition of integrative health care; and
- to identify outcomes and indicators of integrative health care at the practitioner and clinical levels.

The participants at the workshop were drawn from Canada, the United States, the United Kingdom, and China. Presentations were made on the clinical practice of integrative health care at four centres: Marylebone Health Centre, London, United Kingdom; the Duke Center for Integrative Medicine, North Carolina, United States; Shanghai Yueyang Hospital, Shanghai, China; and the Tzu Chi Institute, Vancouver, Canada.

Prior to the workshop the organizers prepared a background paper reviewing the existing literature on the definition of integrative health care and proposing a working definition based on the philosophy and/or values of care, the structure of care, and the process of care. Participants discussed the definition of integrative health care put forward in the background paper, and agreed upon a set of components of integrative health care to serve as the basis for the workshop discussions. They then identified outcomes and indicators for each of these components of integrative health care as experienced and practised at the clinical level.

The primary outcome from this workshop, clarification of what integrative health care is, has two main uses: 1) it can be used by policy makers and health care practitioners to develop new integrative health care programs and 2) it can be used to provide guidance about evaluation and assessment of integrative health care projects currently underway. One of the key findings from the workshop was the need to recognize integrative health care as an "ideal" or "goal" to strive toward. The outcomes from this workshop will aid researchers struggling to address the question: will increasing integration of care lead to better outcomes (e.g., increased health and decreased health care costs)?

The workshop report is currently being disseminated widely to all interested groups. For a copy of the report, please contact Dr. Heather Boon at heather.boon@utoronto.ca.

This workshop was supported by a financial contribution from the Health Policy Research Program, Health Canada (file #6795-15-2001/4430002)

RÉSUMÉ

Les approches intégratives en santé : Définir et opérationnaliser les éléments fondamentaux Rapport de l'atelier, Les 17 et 18 novembre 2002

Le recours croissant aux approches complémentaires et parallèles en santé (ACPS) en Amérique du Nord semble mener à une intégration progressive des ACPS et de la médecine conventionnelle, du moins au niveau des consommateurs individuels. Le recours généralisé aux ACPS et des appels en faveur de leur intégration au régime canadien de soins de santé ont créé un besoin urgent de politiques dans ce domaine. Or, il est difficile de prendre des décisions de politique étant donné le large éventail de perceptions de ce que constituent les approches intégratives en santé. C'est cette problématique qui a motivé la tenue d'un atelier intitulé « Les approches intégratives en santé : définir et opérationnaliser les éléments fondamentaux » dont les objectifs étaient les suivants :

- arriver à un consensus sur une définition pratique des approches intégratives en santé;
- identifier les résultats et les indicateurs des approches intégratives en santé, chez les praticiens et sur le plan clinique.

Les participants à l'atelier venaient du Canada, des États-Unis, du Royaume-Uni et de la Chine. Des présentations ont été faites sur la pratique clinique des approches intégratives en santé à quatre centres : le Marylebone Health Centre (Londres, Royaume-Uni), le Duke Center for Integrative Medicine (Caroline du Nord, États-Unis), l'hôpital Shanghai Yueyang (Shanghai, Chine) et le Tzu Chi Institute (Vancouver, Canada).

Avant l'atelier, les organisateurs avaient rédigé un document d'information dans lequel ils ont fait une enquête bibliographique portant sur la définition des approches intégratives en santé et ont proposé une définition pratique basée sur la philosophie et/ou les valeurs des soins, les structures des soins et le processus des soins. Les participants ont discuté de la définition des approches intégratives en santé proposée dans le document d'information et se sont entendus sur un ensemble d'éléments des approches intégratives en santé sur lesquels s'appuieraient les discussions de l'atelier. Les participants ont alors identifié les résultats et les indicateurs pour chacun de ces éléments des approches intégratives en santé tels qu'ils sont connus et pratiqués sur le plan clinique.

Le résultat primaire de cet atelier, c'est-à-dire la clarification du sens de la notion d'approches intégratives en santé, peut servir à deux principales fins : 1) il peut être utilisé par les décideurs et les professionnels de la santé pour élaborer de nouveaux programmes selon les approches intégratives en santé; 2) il peut être utilisé pour fournir une orientation sur l'évaluation des projets fondés sur les approches intégratives en santé actuellement en cours. L'une des principales conclusions de l'atelier a fait état du besoin de reconnaître les approches intégratives en santé comme un « idéal » ou un « objectif » à atteindre. Les résultats de cet atelier aideront les chercheurs qui sont aux prises avec la question suivante : une intégration croissante des soins mènera-t-elle à de meilleurs résultats (p. ex. une meilleure santé et une réduction des coûts liés aux soins de santé)?

Le rapport de l'atelier est actuellement diffusé à grande échelle à tous les groupes intéressés. Pour obtenir une copier du rapport, veuillez communiquer avec Dr. Heather Boon à heather.boon@utoronto.ca .

Cet atelier a reçu l'appui financier du Programme de recherche sur la politique en matière de santé, Santé Canada (n° de dossier 6795-15-2001/4430002).

EXECUTIVE SUMMARY
Integrative Health Care:
Defining and Operationalizing the Fundamental Elements (November 17-18, 2002)
Workshop Report

Introduction

The increasing use of complementary and alternative health care (CAHC) in North America appears to be leading to a growing integration of CAHC with conventional medicine, at least at the individual consumer level. The widespread use of CAHC and calls for its integration into the Canadian health care system have created an urgent need for policy in this area. Yet it is difficult to make policy decisions given the wide range of perceptions about what constitutes integrative health care. This was the impetus for holding a workshop on this topic.

Objectives and Participants

The workshop on Integrative Health Care: Defining and Operationalizing the Fundamental Elements was convened with the following objectives:

- to achieve consensus on a working definition of integrative health care; and
- to identify outcomes and indicators of integrative health care at the patient, practitioner and clinical levels.

The participants at the workshop were drawn from Canada, the United States, the United Kingdom, and China. Presentations were made on the clinical practice of integrative health care at four centres: Marylebone Health Centre, London, United Kingdom; the Duke Center for Integrative Medicine, North Carolina, United States; Shanghai Yueyang Hospital, Shanghai, China; and the Tzu Chi Institute, Vancouver, Canada.

Prior to the workshop the organizers prepared a background paper reviewing the existing literature on the definition of integrative health care and proposing a working definition based on the philosophy and/or values of care, the structure of care, and the process of care. Participants discussed the definition of integrative health care put forward in the background paper, and agreed upon a set of components of integrative health care to serve as the basis for the discussion of outcomes and indicators for the duration of the workshop.

Integrative health care, as described by the participants:

- takes a person-centred, person-empowering approach to health care;
- recognizes inter-relationships among physical, mental, social, environmental, and spiritual dimensions of health and well-being;
- facilitates healing;
- allows for and considers multiple disciplines and modalities;
- requires inter-disciplinary and inter-professional working relationships among practitioners;
- provides access to and support for needed or desired care at the health systems level;
- supports continuity and coordination in care;
- incorporates a process of organizational (professional, clinical, institutional, systems-level) development, reflection, and evaluation on activities, process, and outcomes of care.

Proposed outcomes of integrative health care

Outcomes of an approach that centres on and empowers the person seeking care might include the following:

- The person senses that their needs are being met and the person has a sense of working in partnership with the practitioner.
- The person has a greater sense of responsibility for their health and well-being.
- The person has an increased sense of empowerment.
- The person has an increased sense of meaning in life.

Outcomes of an approach that recognizes the inter-relationships among physical, mental, social, environmental, and spiritual dimensions of health and well-being might include the following:

- The approach to care deals with the whole person (body, mind, spirit, social context).
- The approach to care focuses on health promotion and disease prevention.
- The practitioner involves the person's social system (family, community, culture) in the care process.
- The person and the practitioner have an increased awareness that human health is part of ecosystem health.
- The person has an increased awareness of self and of the spiritual dimensions of health, and a greater understanding of illness and death as part of living and life.
- The practitioner has an increased sense of well-being as care-giver.
- The person, the practitioner, and their community show evidence of increased health and well-being.

Outcomes of care that facilitates healing (which is broader than the treatment of disease) might include the following:

- The person's quality of life improves.
- The care process focuses on health and healing rather than disease and treatment.
- The person has an increased awareness of self, self-efficacy, and personhood as a result of the exploration of the process of illness and health.

Outcomes of care that incorporate multiple disciplines and modalities might include the following:

- There is a demonstrable pattern of access to and use of conventional and complementary or alternative health care systems, disciplines, and modalities.

Outcomes of care that involve effective inter-disciplinary and inter-professional relationships might include the following:

- Evidence of inter-disciplinary or inter-professional working relationships among practitioners.
- A demonstrable culture of respect, shared vision, team approach, consensus, and synergy among practitioners.
- A demonstrable pattern of shared decision-making, both among practitioners and with persons seeking care.

Outcomes of systems that are responsive to the expressed desires or needs of the person seeking care might include the following:

- The person's needs are met through a collaborative process that considers the accessibility of care, the available resources, the person's beliefs and choices, the practitioner's experience, and the evidence for a given therapy.

- Decisions are made with a spectrum of informational supports, including the practitioner's knowledge and experience, the person's knowledge and experience, peers, advocacy groups, health intermediaries, information specialists, literature, and informational databases.
- Access to care is continually improved by identifying constraints and working to overcome them.

Outcomes of efforts to provide continuity and coordination in care might include the following:

- Structures to enable or enhance communication, learning, and coordinated action.
- Processes to enable or enhance team work among practitioners and shared space in providing care.
- A care process (case management and clinical pathways) that provides evidence that there is a sharing of paradigms with regard to the various levels or aspects of health.

Outcomes of organizational development, reflection, and evaluation with regard to activities, processes, and outcomes of care might include the following:

- Evidence of reflection, learning, and development with regard to met or unmet needs, the appropriateness of care, the effectiveness of care, risks and safety, and activities for the practitioner and the person seeking care.
- Evidence of development at the professional, clinical, institutional, regulatory, and systems level with regard to the appropriateness, accessibility, acceptability, equity, effectiveness, and efficiency of care (indicators to be determined.)

Indicators or measures were suggested for the above outcomes.

Policy and Program Implications

The key purpose of this workshop was to provide clarification of the concept integrative health care. Such clarification has two main uses: 1) they can be used by policy makers and health care practitioners to develop new integrative health care programs and 2) they can be used to provide guidance about evaluation and assessment of integrative health care projects currently underway. One of the key findings from the workshop was the need to recognize integrative health care as an "ideal" or "goal" to strive toward. The outcomes from this workshop will aid researchers struggling to address the question: will increasing integration of care lead to better outcomes (e.g., increased health, and decreased health care costs)?

Next steps

A revised version of the background paper will be published, as well as a paper discussing the response of the workshop to the background paper. Participants will be consulted with respect to additional next steps. The workshop report is currently being disseminated widely to all interested groups. For a copy of the report, please contact Dr. Heather Boon at heather.boon@utoronto.ca .

This workshop was supported by a financial contribution from the Health Policy Research Program, Health Canada (file #6795-15-2001/4430002)

FINAL WORKSHOP REPORT
Integrative Health Care:
Defining and Operationalizing the Fundamental Elements
November 17-18, 2002

Introduction

The increasing use of complementary and alternative health care (CAHC) in North America has necessarily raised questions and concerns about the integration of CAHC with conventional medicine. While conventional medicine increases its efforts to improve the integration of care within its own therapeutic discipline with such initiatives as multi-disciplinary clinics and case managers, the potential integration of conventional medicine with CAHC has received less attention. It is feared that the interplay between the two might be more typified by a fragmentation of services rather than a beneficial synergy. When this concern has been addressed, there appears to be little consistency in the framing of the issue. Definitions and descriptions of integration of CAHC and conventional medicine vary widely among practitioners, researchers, policy makers and users. Partly, this is because there have been few attempts to fully conceptualize integration and integerative health care. This makes it difficult to assess when integrative health care is actually happening.

Why is Integration of Complementary and Alternative Health Care A Policy Priority?

Approximately half of all Canadians use CAHC (including the use of natural health products such as herbs and supplements as well as therapies such as traditional Chinese medicine and acupuncture, homeopathy, and chiropractic) in the management of their health.(1) Although many patients are already integrating CAHC with conventional medicine in order to meet their individual health care needs, (2, 3) there is usually little communication and collaboration between providers, supporting what Berwick and Smith have called "disintegrating" care.(4) Integrative medicine or health care, where CAHC and conventional medicine practitioners work together in an environment that facilitates understanding of each other's strengths, weaknesses and expertise, has been suggested as the only way to ensure optimum patient care.(5)

The widespread use of CAHC and calls for its integration into the Canadian health care system have created an urgent need for policy in this area. For example, natural health products continue to be regulated under out-dated food regulations and most CAHC providers operate without any regulatory framework, creating a "buyer beware" atmosphere for Canadians who wish to access high quality products and services. Introduction of CAHC-related policy was identified as a priority by the Standing Committee on Health, which recommended the creation of an Office of Natural Health Products in 1998.(6) The importance of this policy area is highlighted by the fact that less than two years after its creation, this office has been upgraded to the Natural Health Products Directorate.

Other Departments within Health Canada are also working to understand and develop policy to support the increasing demand for CAHC products and services by Canadians. For example, a collection of seven papers, "Perspectives on Complementary and Alternative Health Care" was commissioned and recently released by the Health Systems Division of Health Canada. One of these papers specifically addresses the integration of CAM with the conventional Canadian health care system(7) and provides foundational material for the workshop proposed here.

Policy and Program Implications of the Key Findings From the Workshop

The workshop Planning committee is continuing to function as an Integrative Health Care Working Group. They have combined the workshop discussion results and the draft background paper to develop a framework for conceptualizing integrative care in terms of four key components: philosophy/values; structure; process; and outcomes. It can be used to design and implement new programs as well as to develop assessment strategies for new and existing integrative health care programs.

One of the key findings from the workshop was the need to recognize integrative health care as an "ideal" or "goal" to strive toward. Thus it is important to assess where along the continuum of health care delivery models (from parallel practice to truly integrative health care) each group or program is and to set policy and program goals to move along the continuum toward integrative care. If fully integrative health care is the goal of a program, it is important to begin to document progress toward that goal. Bench-marking progress along the continuum by using some of the indicators identified in the workshop report is an important way to measure that progress. This will also allow programs at similar points along the continuum to be compared with programs at a similar point along the continuum (e.g., comparing apples with apples) with respect to effectiveness and cost-effectiveness. In addition, this would allow researchers to begin to address the question: will increasing integration of care lead to better outcomes (e.g., increased health, decreased health care costs)?

It is also interesting to note that there is substantial interest in the workshop results by representatives from Provincial Ministries of health who see a clear connection of our work with primary care capacity building, chronic care and mental health initiatives. Already we have received requests for our papers.

Implementation of the Findings

The findings from the workshop will be used in a number of ways. Many of the participants from the workshop are trying to assess their programs by incorporating some of the indicators and outcomes discussed at the workshop. The Integrative Heath Care Working Group is continuing to refine the ideas discussed at the workshop and actively disseminate these to a diverse audience. This workshop was a catalyst for many activities that are just beginning to be identified by invitations to discuss the workshop findings with a number of different groups (see dissemination plan below). Ongoing collaboration with the Natural Health Products Directorate, Health Canada and various

Provincial Ministries of Health will ensure that the outcomes from this workshop continue to influence policy development in the future.

Consolidation of Knowledge Gained

Despite the recent spate of literature discussing the integration of CAHC services with conventional medicine[8-15], the terminology and conceptualization of integrative health care remains varied and confusing.

Background Paper on Integrative Health Care

Prior to the workshop the organizers prepared a background paper reviewing the existing literature on the definition of integrative health care and proposing a working definition based on the philosophy and/or values of care, the structure of care, and the process of care (see Appendix A). As proposed by the organizers, integrative health care:

- seeks, through a partnership of patient and practitioner, to treat the whole person, to assist the innate healing properties of each person, and to promote health and wellness as well as the prevention of disease (philosophy and/or values);

- is an interdisciplinary, non-hierarchical blending of both conventional medicine and complementary and alternative health care that provides a seamless continuum of decision-making and patient-centred care and support (structure); and

- employs a collaborative team approach guided by consensus building, mutual respect, and a shared vision of health care that permits each practitioner and the patient to contribute their particular knowledge and skills within the context of a shared, synergistically charged plan of care (process).

The purpose of this document was to guide and stimulate the workshop discussions. A revised version of this paper has now been submitted to the journal "Archives of Internal Medicine" for consideration for publication.

Summary of the Workshop

Based on lack of clarity of what integrative health care is and the need to fill this gap, we organized a workshop on Integrative Health Care: Defining and Operationalizing the Fundamental Elements. The objectives of the workshop were to:

- to achieve consensus on a working definition of integrative health care; and
- to identify outcomes and indicators of integrative health care at the clinical level.

The agenda from the workshop is included in Appendix B. The workshop began with descriptions of four very different models of integrative care that are currently in

operation to provide workshop participants with the wide range of ways in which integrative health care takes place. In addition to the background paper, these presentations served as a basis for participants' discussions. The presentation covered four different models of integrative health care:

- Marylebone Health Centre, London, United Kingdom;
- the Duke Center for Integrative Medicine, North Carolina, United States;
- Shanghai Yueyang Hospital, Shanghai, China; and
- the Tzu Chi Institute for Complementary and Alternative Medicine, Vancouver, Canada.

Workshop participants (see Appendix D) identified the similarities and differences among these models in a moderated plenary session. This led to a discussion of the nature of integrative health care.

There was a lively debate about the terms of the definition. Some participants felt that the definition provided in the background document was in fact a mission statement or a goal of how integrative health care should be delivered. As such, it did not seem to acknowledge degrees of, or stages in the development of, integrative health care. Several participants also observed that the definition as it stands goes beyond describing components of integrative health care to stating hypotheses about the nature of integrative health care. They urged that the definition should not include implied hypotheses, to avoid possible confusion between evidence contradicting the hypotheses and evidence contradicting the existence of integrative health care.

The workshop participants agreed on a set of components of integrative health care that would serve as the basis for the discussion of outcomes and indicators for the duration of the workshop.

Integrative health care:

- Takes a person-centred, person-empowering approach to health care.
- Recognizes inter-relationships between physical, mental, social, environmental, and spiritual dimensions of health and well-being.
- Facilitates healing.
- Allows for and considers multiple disciplines and modalities.
- Requires inter-disciplinary and inter-professional working relationships among practitioners.
- Provides access to and support for needed or desired care at the health systems level.
- Supports continuity and coordination in care.
- Incorporates a process of organizational (professional, clinical, institutional, systems-level) development, reflection, and evaluation on activities, process, and outcomes of care.

The workshop participants then divided into three working groups to identify outcomes of integrative health care, and where possible, indicators of these outcomes. Outcomes were defined as *all of the possible products or results that might occur when a particular program or approach is used*. Indicators were defined as *specific items that can be measured or assessed*. The working groups reported back in plenary to share their ideas and obtain feedback from the whole group.

The findings regarding the content of these debates are summarized below. Additional detail can be found in the Final Workshop Report (see Appendix C).

Proposed outcomes of integrative health care

Outcomes of an approach that centres on and empowers the person seeking care might include the following:

- The person senses that their needs are being met and the person has a sense of working in partnership with the practitioner.
- The person has a greater sense of responsibility for their health and well-being.
- The person has an increased sense of empowerment.
- The person has an increased sense of meaning in life.

Outcomes of an approach that recognizes the inter-relationships among physical, mental, social, environmental, and spiritual dimensions of health and well-being might include the following:

- The approach to care deals with the whole person (body, mind, spirit, social context).
- The approach to care focuses on health promotion and disease prevention.
- The practitioner involves the person's social system (family, community, culture) in the care process.
- The person and the practitioner have an increased awareness that human health is part of ecosystem health.
- The person has an increased awareness of self and of the spiritual dimensions of health, and a greater understanding of illness and death as part of living and life.
- The practitioner has an increased sense of well-being as care-giver.
- The person, the practitioner, and their community show evidence of increased health and well-being.

Outcomes of care that facilitates healing (which is broader than the treatment of disease) might include the following:

- The person's quality of life improves.
- The care process focuses on health and healing rather than disease and treatment.
- The person has an increased awareness of self, self-efficacy, and personhood as a result of the exploration of the process of illness and health.

Outcomes of care that incorporate multiple disciplines and modalities might include the following:

- There is a demonstrable pattern of access to and use of conventional and complementary or alternative health care systems, disciplines, and modalities.

Outcomes of care that involve effective inter-disciplinary and inter-professional relationships might include the following:

- Evidence of inter-disciplinary or inter-professional working relationships among practitioners.
- A demonstrable culture of respect, shared vision, team approach, consensus, and synergy among practitioners.
- A demonstrable pattern of shared decision-making, both among practitioners and with persons seeking care.

Outcomes of systems that are responsive to the expressed desires or needs of the person seeking care might include the following:

- The person's needs are met through a collaborative process that considers the accessibility of care, the available resources, the person's beliefs and choices, the practitioner's experience, and the evidence for a given therapy.
- Decisions are made with a spectrum of informational supports, including the practitioner's knowledge and experience, the person's knowledge and experience, peers, advocacy groups, health intermediaries, information specialists, literature, and informational databases.
- Access to care is continually improved by identifying constraints and working to overcome them.

Outcomes of efforts to provide continuity and coordination in care might include the following:

- Structures to enable or enhance communication, learning, and coordinated action.
- Processes to enable or enhance team work among practitioners and shared space in providing care.
- A care process (case management and clinical pathways) that provides evidence that there is a sharing of paradigms with regard to the various levels or aspects of health.

Outcomes of organizational development, reflection, and evaluation with regard to activities, processes, and outcomes of care might include the following:

- Evidence of reflection, learning, and development with regard to met or unmet needs, the appropriateness of care, the effectiveness of care, risks and safety, and activities for the practitioner and the person seeking care.
- Evidence of development at the professional, clinical, institutional, regulatory, and systems level with regard to the appropriateness, accessibility, acceptability, equity, effectiveness, and efficiency of care.

Indicators or measures were suggested for the above outcomes (see Appendix C for details).

In the past, discussions of the integration of CAHC with conventional health care systems have generally been conducted in isolation, without reference to the policy and theories developing with respect to the integration of different health care services within the health care system. Based on the discussions of the workshop, the Integrative Health

Care Working Group is currently drafting another paper, tentatively titled "Towards Integrative Health Care: The Continuum of Health Care Delivery Models" that will begin to fill that gap.

In addition, the workshop built directly on preliminary discussions of integration issues at several earlier meetings. The first Integrative Medicine Industry Leadership Summits were hosted by John Weeks, a US health care economist and integration expert, in the United States in 2000, 2001 and 2002 and resulted in the establishment of the Collaboration for Health Care Renewal (CHCR). Two members of the workshop planning committee have now been invited to join working groups that are part of CHCR. H. Boon is part of the Design Principles Working Group and B. Findlay is a member of both the Integrative Clinical Services Consortium and the CHRF Leadership Team. H. Boon has been asked to present the findings of the workshop to her working group at the 2003 Summit, where they will form the basis for the group's discussions at the meeting.

Finally, the all members of the Integrative Health Care Working group (formerly the workshop planning committee) is part of a successful Inter-disciplinary Capacity Enhancement (ICE) team grant funded by the Canadian Institutes for Health Research (CIHR). A key focus of this ICE team will to build research capacity and quality in the area of health services and policy research on CAHC and integrative health care. Thus, the ideas and projects that began at this workshop now have a forum (and funding) to be continued over the next five years.

Plans and Prospects for Publications and Dissemination of the Proceedings to Policy Makers

Plans for publication and dissemination of the proceedings to policy makers and other interested parties fall into three categories: dissemination of the final report, scholarly publications, and personal meetings/presentations. Each is discussed in more detail below.

Dissemination of the Final Report

The final report from the workshop (see Appendix C) has been circulated to all the workshop participants (which included three policy makers: Joan Simpson and Michael Smith from the Natural Health Products Directorate, Health Canada and David Hoe, HIV/AIDS Policy, Coordination and Programs Division, Centre for Infectious Disease Prevention and Control, Health Canada). In addition, the one page summary or executive summary from this report, together with a contact for obtaining additional information was (or will be) circulated to the following individuals, groups and networks:

- Cathy Mattern, Women's Health Bureau, Health Canada
- The Toronto CAM Research Network
- The Sociobehavioural Cancer and Complementary/Alternative Therapies (CAT) group

- The Alberta CAM Research Network
- The Canadian Naturopathic Association
- The Canadian Chiropractic Association
- The Canadian Consortium of Integrated Health Care
- The Collaboration for Health Care Renewal

As indicated above, Provincial Ministries of Health have expressed strong interest in the workshop papers, indicating that the relevance of the workshop results extends beyond the integration of CHAC and conventional health care. Examples are:

- Gordon Kumagai, Coordinator of Special Projects, Direct Payment and Regulatory Programs Policy Unit, Programs Policy Branch, Ontario Ministry of Health and Long-Term Care
- Jeff Goodyear, Program Policy Branch, Direct Payment and Regulatory Programs Unit, Ontario Ministry of Health and Long Term Care
- Valerie Tregillus, Director, Strategic Initiatives, Policy and Program Management. British Columbia Ministry of Health Services.
- Ms. Betty Jeffers, Strategic Planning Division, Strategy Development Branch, Alberta Health & Wellness

Scholarly Publications

A shorter, revised version of the background paper, titled "Integrative Health Care: Arriving at a Working Definition," has been submitted for publication to the Journal Archives of Internal Medicine. In addition, a second manuscript tentatively titled "The Continuum of Integrative Health Care: Setting Benchmarks Along the Road to Complete Integration," is in preparation by the working group and is expected to be submitted for publication in the summer of 2003. Finally, a third paper detailing the practical challenges and opportunities for assessing integrative care will be drafted later in 2003.

Personal Meetings/Presentations

Key findings from the workshop have been (or will be) presented and discussed at the following meetings:

Date	Presenter(s)	Individual or Conference
05/12/02	H. Boon and M. Verhoef	The 9th Annual Symposium on Complementary Care, Exeter, UK.
06/01/03	H. Boon	Jeff Goodyear and Jacklyn Campbell, Senior Policy Analyst, Program Policy Branch, Direct Payment and Regulatory Programs Unit, Ontario Ministry of Health and Long Term Care, Toronto
23/01/03	B. Findlay	Lecture/Seminar for the ICAM (Issues in Complementary and Alternative Medicine) Course at the University of B.C. (Faculty of Pharmacy)
21/02/03	D. O'Hara	Catholic Health Association of Canada, Leadership Program, Winnipeg

01/03/03	H. Boon	Michael Smith, Senior Policy Advisor, Natural Health Products Directorate, Health Canada, Winnipeg
03/04/03	H. Boon and B. Findlay	Collaboration for Health Care Renewal Foundation Summit, Phoenix, Arizona, USA
Spring or summer 2003	H. Boon	Design Principles Working Group of the Collaboration for Health Care Renewal Foundation Summit Retreat, Boston, Mass., USA
June 2003	H. Boon, B. Findlay and M. Verhoef	Presentation to the Alberta CAM Research Network

Summary of the Objectives and Methods of the Workshop

A full report of the objectives, methods and findings of the workshop may be found in the Final Workshop Report (see Appendix C).

References

1. Ramsay C, Walker M, Alexander J. Alternative Medicine in Canada: Use and Public Attitudes. Public Policy Sources Number 21. Vancouver: The Fraser Institute; 1999.
2. Boon H, Brown JB, Gavin A, Kennard MA, Stewart M. Breast cancer survivors' perceptions of complementary/alternative medicine (CAM): Making the decision to use or not to use. Qualitative Health Care 1999;9(5):639-653.
3. Boon H, Stewart M, Kennard MA, Gray R, Sawka C, Brown JB, et al. The use of complementary/alternative medicine by breast cancer survivors in Ontario: Prevalence and perceptions. Journal of Clinical Oncology 2000;18(13):2515-2521.
4. Berwick D, Smith R. Cooperating, not competing, to improve health care [editorial]. Bmj 1995;310(6991):1349-50.
5. Weeks J. The emerging role of alternative medicine in managed care. Drug Benefit Trends 1997;9(4):14-16, 25-28.
6. Volpe JC. Natural Health Products: A New Vision. Ottawa: Report of the Standing Committee on Health; 1998 November.
7. Advisory Group on Complementary and Alternative Practices and Therapies. Towards an Integrative Health System. Ottawa: Health Systems Division, Health Policy and Communications Branch, Health Canada; 2000 July.
8. Pelletier KR, Astin JA, Haskell WL. Current trends in the integration and reimbursement of complementary and alternative medicine by managed care organizations (MCOs) and insurance providers: 1998 update and cohort analysis. American Journal of Health Promotion 1999;14(2):125-133.
9. Best A, Herbert C. Two solitudes of complementary and conventional medicine. Where are we going? Canadian Family Physician 1998;44:953-955.
10. Peters D, Chaitow L. Integrating Complementary Therapies in Primary Care: A Practical Guide for Health Professionals. Toronto: Churchill Livingstone; 2002.
11. Leatt P, Pink GH, Guerriere M. Towards a Canadian Model of Integrated Healthcare. HealthcarePapers 2000;1(2):13-35.

12. Maizes V, Caspi O. The principles and challenges of integrative medicine. WJM 1999;171:148-149.
13. Meeker WC. "Integration" -- The New Buzzword. In.: ChiroWeb.com; 2002.
14. Bell IR, Caspi O, Schwartz GE, Grant KL, Gaudet TW, Rychener D, et al. Integrative medicine and systemic outcomes research: issues in the emergence of a new model for primary health care. Arch Intern Med 2002;162(2):133-40.
15. Meeker WC. Public demand and the integration of complementary and alternative medicine in the US health care delivery system. J Manipulative Physiol Ther 2000;23:123-126.

Appendix A:

Background Paper

Draft: Not for distribution without permission from the corresponding author

Integrative Health Care: Arriving at a Working Definition

Heather Boon PhD[1], Marja Verhoef PhD[2,4], Dennis O'Hara ND DC PhD[3], Barb Findlay RN[4] and Nadine Majid BSc[5]

[1] Faculty of Pharmacy, University of Toronto
[2]Faculty of Medicine, University of Calgary
[3]St. Michael's College, University of Toronto
[4]Tzu Chi Institute, Vancouver
[5]Medical Student, McMaster University

Corresponding Author

Heather Boon, PhD
Faculty of Pharmacy
University of Toronto
19 Russell Street
Toronto, ON
M5S 2S2 Canada

Telephone: 416-946-5859
Fax: 416-978-1833
Email: heather.boon@utoronto.ca

INTRODUCTION

The increasing use of complementary and alternative health care (CAHC) in North America has created both new opportunities and concerns. [1-4] With the subsequent growing interaction between CAHC and conventional medicine comes the concern that this interplay might be more typified by a fragmentation of services rather than a beneficial synergy. [5-7] Furthermore, it is feared that potentially adverse interactions involving CAHC and natural health products on the one side, and conventional therapies and prescription medications on the other, are not being properly identified and tracked.[8,9] Even while conventional medicine increases its efforts to improve continuity of care within its own therapeutic discipline with such initiatives as multi-disciplinary clinics and case managers, the potential continuity between conventional medicine and CAHC has received less attention. When this concern has been addressed, there appears to be little consistency in the framing of the issue. Various centres, clinicians and researchers seem to have varying definitions for the integration of CAHC and conventional medicine. Accordingly, it is not only difficult to address this matter on a more global level, it is also difficult to assess when integrative medicine is actually happening.

This paper will attempt to provide a preliminary definition for integrative health care that can win wide acceptance while not purporting to be either the sole or a universal definition. It will explore current efforts to define this approach, providing the reader with a brief review of current literature and suggesting a context for constructing common language and terminology. The paper will also describe the elements that would seem to be present in a comprehensive understanding of integrative health care. These elements or themes will be studied in some detail so that they might subsequently be operationalized as objective markers in settings where integrative health care programmes are being developed and evaluated.

Integrative health care is already occurring, if only unintentionally, as consumers meld together the health care approaches that they desire. [10] The interplay between CAHC and conventional medicine will undoubtedly continue as consumer demand rises, and this will be the case whether or not health care professionals and researchers devise common and clear terminology and priorities. [11] A definition of integrative health care that garners wide acceptance will facilitate research involving CAHC and conventional medicine, as well as the continuing evolution of the integration of these two. The development of common terminology will provide a context for intelligible dialogue, and will assist in policy decisions and development. At the same time, it is recognized that as society's approach to health, health policy, and therapeutic protocols continue to evolve, any definition of integrative health care will undergo its own gradual evolution.

CLARIFYING TERMINOLOGY

There is great diversity in CAHC, whether one is considering types of therapies, types of delivery, degrees of legitimacy and public acceptance, or levels of scientific validation by evidence based medicine. [12-15] Therefore, it is not surprising that there is a comparable diversity in terminology; no single set of terms can hope to capture every distinction and nuance of this landscape. Nevertheless, it is necessary to stake out one's position within this context, and such is the case here.

Integrative Health Care, not Integrated Medicine

Although the term CAM (complementary and alternative medicine) is commonly used in the literature, the designation of CAHC (complementary and alternative health care) is increasingly being used. This change represents the growing acknowledgement that human health has a broad range of determinants and interrelationships, not the least of which are: income and social status, personal education, social support networks, security of home and employment, workplace conditions, lifestyle habits, pre- and post-natal development, biological and genetic endowments, physical environment, and accessibility to health care services. [10,16] This shift to a population health approach to health care assessment and planning recognizes that medical care is but one of many factors that contribute to the health of an individual or societies. Hence, the broader term—health care—is used instead of medicine when describing complementary and alternative health care.

Similarly, the term "integrative" is preferred to "integrated" since the latter implies that the event of integration has not only occurred but is also completed. As the literature notes, integrating the range of health care therapies and practitioners in a way that provides the most effective and cost effective care to the patient is far from achieved. The evolution of this approach to patient care seems to be more nascent than finalized. Consequently, the term "integrative" is used since it infers that the process is both dynamic and still evolving.

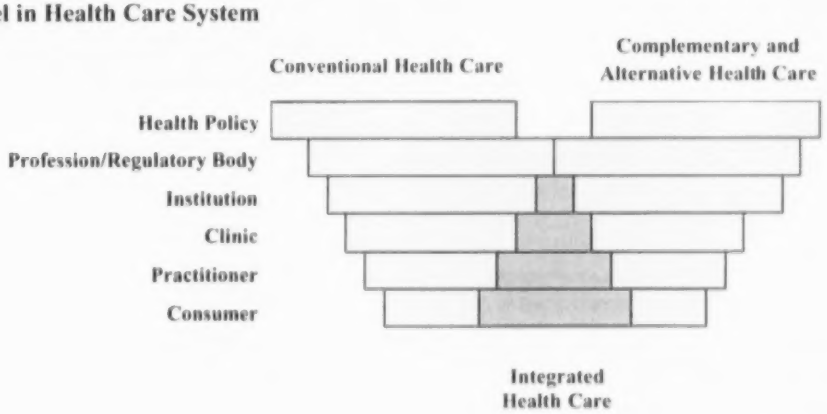
Levels of Integration

A diversity of definitions for integrative health care can also result due to the various levels and degrees of integration that can occur. Various authors may be providing descriptions and definitions for different levels of integration, resulting in definitions that share some common elements but not others. Therefore, it is important to declare which level of integration is being considered when a definition or policy recommendations are being proposed.

Tataryn and Verhoef have examined the levels and degrees of integration that can occur between conventional and CAHC, particularly as a result of what they have identified as an "upward pressure" for integration that begins with consumers melding together a disparate selection of services into a collective that attends to their health care needs and beliefs. [10] Six levels of integration are described, beginning with consumers who have

forced integration upon the health care system through their demands for more access to complementary care. These demands have prompted some practitioners to become better educated in the practice of CAHC, and to adopt some of these therapies into their practices or to refer their patients to those who can provide such care. While the degree of integration at the practitioner level is undoubtedly less than occurring among consumers/patients, it is arguably more advanced than is presently happening at the clinical level. (See Figure 1 below.) Integrative health care clinics are emerging in an effort to offer patients comprehensive care that supports the promotion and restoration of their health, and to provide the instruction that they need to be more active in their own care.

Figure 1: The "Integration Pyramid": Degrees of Integration between Conventional and CAHC as illustrated by Tataryn and Verhoef [10]



At the institutional level, integration is more nascent than developed as few teaching and health care institutions have introduced courses and treatment protocols that permit CAHC to become an integral part of the health system. Only recently have some of the regulatory bodies for conventional medicine addressed the integration of CAHC as part of their practice guidelines and standards of practice, and in some cases, have permitted their registrants to refer to or collaborate with certain CAHC professions. [17,18] If the level of integration of conventional medicine and CAHC is relatively sparse at the institutional level, it is even less developed at the level of health policy. However, economic and consumer pressures have recently prompted new dialogue and efforts by third party payers and government agencies in this regard (e.g., three Canadian Institutes of Health Research now include CAHC within their funding mandates).[10]

During the remainder of this paper, we will be focussing primarily on the practitioner and clinical levels of integration.

What Integrative Health Care is not

As is often the case with complex subjects, it is somewhat easier to say what a certain thing is not, rather than provide a succinct and comprehensive description of what it is. The terms commonly used to describe various practice styles can hold different meanings for different people, especially since these terms are often not well-defined. In keeping with William Meeker's discussion of practice styles, [19,20] we would argue that integrative health care is not sufficiently captured by any one of the following practice styles: (see Table 1 for a comparison)

a) **Parallel Practices** result when a consumer integrates therapies from a variety of practitioners who do not communicate with each other concerning the care of that patient. Consequently, these medical practices are not examples of integrative health care.

b) **Collaborative Practices** occur when practitioners, who normally practice independently from each other, share information concerning a particular patient who has been referred to each of them. Due to both the ad-hoc nature of these collaborations and the focus on the treatment of a particular condition rather than the health of the patient, collaborative practices are not examples of integrative medicine.

c) **Consultative Practices**, which commonly occur within departments in institutions, allow expert opinion to be shared among practitioners who integrate patient care on a case management level. However, the focus remains on the treatment of disease rather than the care of a patient.

d) **Coordinated Practices** occur when a formalized administrative structure requires communication and the sharing of patient records among professionals who are members of the team intentionally gathered to provide treatment for a particular disease or to deliver a specific therapy. Due to the narrow focus on the delivery therapy rather than the broader healthcare needs of the patient, this is not an example of integrative medicine.

Nor is the model of integration that we wish to describe emulated by either of the following models that are presently operating.

a) **Co-optation Model** – where CAHC practices are simply delivered by a conventional health care practitioner as that practitioner incorporates a portion of a CAHC therapy or discipline within the context of conventional Western bio-medicine. [10,21] This merely represents the assimilation of a fragment of an entire health system into the practice of mainstream medicine and does not represent an integration or blending of the epistemological or cosmological perspectives that define either approach. [21]

b) **Co-existence Model** – where a conventional medicine practitioner communicates and collaborates with a practitioner of a CAHC therapy or discipline while each maintains distinct professional and practice autonomy. [10] Mere inter-professional co-operation for a specific patient complaint does not result in integrative health care for a patient.

Table 1: Comparison of Practice Styles with Integrative Health Care [10,19-21]

Practice Style		...is not Integrative Health Care because it...
Parallel Practice	the consumer integrates a variety of therapies from a selection of practitioners who maintain autonomous practices and have little communication with each other	has no effective communication involving practitioners and patient nor is there deliberately coordinated and planned patient care
Collaborative Practice	the consumer integrates a variety of therapies provided by a group of practitioners who share information concerning the patient's care on a case-by-case basis while maintaining significant practice autonomy (e.g., when referrals are made between practitioners)	does not provide integrative health care because the patient continues to carry the primary responsibility for the management of her/his health care and the practitioners' services are directed at the treatment of a particular condition rather than the health of the patient
Consultative Practice	expert opinion is shared between practitioners, providing integration on a case management level (e.g., within departments in institutions)	does not provide integrative health care because the focus remains on the treatment of a disease and not the care of a patient
Coordinated Practice	formalized administrative structure requires communication and the sharing of patient records among the professionals who are members of the same team and who intentionally consult and collaborate with one another (e.g., specialty clinics that focus on the treatment of a particular condition)	does not provide integrative health care because the focus remains on the treatment of a disease or the delivery of a therapy rather than the care of a patient.
Practice Model		**...is not Integrative Health Care because it...**
Co-optation Model	the conventional practitioner incorporates some CAHC therapies into her/his medical practice	represents the assimilation of a fragment of an alternative or complementary therapy into the practice of mainstream medicine and does not represent an integration or blending of the epistemological or cosmological perspectives that define either approach.
Co-existence Model	a conventional practitioner communicates and collaborates with a CAHC practitioner for the treatment of a particular patient's complaint while each maintains distinct professional and practice autonomy	focuses on the treatment of a particular complaint without sufficient consideration of the overall health of the patient and does not represent a concerted attempt to share and blend perspectives on health and healing.

Towards a Definition of Integrative Health Care

Every definition reflects a particular worldview, describes a specific context, and is usually formulated with a specific agenda in mind. Since these factors can be dynamic and in flux, and since different people and cultures can hold varying worldviews, it is not surprising that definitions are often the subject of debate, revision and evolution. This is particularly true of a definition for integrative health care. While no single definition is likely to satisfy all readers, a review of existing attempts to define the term might lead to a new understanding that can receive wide acceptance.

A review of the literature indexed in Medline, PubMed, and Alt HealthWatch, using the MeSH headings Integration, Integrative Medicine, Integrated Health Care, and Collaborative Practice, was completed to identify all articles that purported to discuss or define the concept of integrative health care. In addition, the reference lists of all articles were hand searched for additional non-indexed material that was relevant to our discussion. Recognizing that authors used many different terms to describe what we consider to be integrative health care, we focused on the definitions and explanations of the concepts used in each document rather than the specific terminology. All definitions, principles, components and/or features of the concept "integrative health care" were identified and extracted from each document. These were then independently reviewed by at least two authors using basic content analysis [22,23] to identify key themes. Consensus on the themes was achieved at a face-to-face team meeting.

Three key themes emerged from the many attempts in the literature to define integrative health care, namely: 1) **philosophy and /or values** which describe an underlying worldview or set of values as the fundamental basis for guiding the emergence of integrative health care; 2) **structure**, where integrative health care was described by its constituent elements and the infrastructure that links them together; and 3) **process**, where integrative health care was described by the unique process of interaction between the patients and practitioners involved—i.e., by the internal dynamics of the integration. (See Table 2 below). In addition, definitions often make reference to the intended outcome of integrative health care. Each of these themes will be examined in more detail.

Philosophy and/or values

> *Integrative Medicine, then, shifts the orientation of medicine to one of healing rather than disease, engaging the mind, spirit, and community as well as the body. The integrative approach is based on a partnership of patient and practitioner within which conventional and alternative modalities are used to stimulate the body's innate healing potential.* [24] (p. 67)

For some commentators, the defining feature of integrative health care is the philosophy and values that underlie this approach to patient care. The structure, process and outcomes of integrative care subsequently follow from this defining and foundational epistemology. For them, the mere addition of selective aspects of CAHC therapies with conventional medicine does not result in integrative health care since this does not

represent an acceptance and integration of the holistic principles that tend to characterize CAHC. This is especially true when the term integration is used in its traditional lexicographic sense—i.e., the incorporation of equals into a common way of being. [25] The co-optation or assimilation of pieces of a whole system of care, removed from their proper context, does not represent the collaboration of equals. However, when these values and philosophy are respectfully incorporated with the technical rigor of conventional medicine, a "higher-order system of systems of care" can result that draws "on both conventional and CAM approaches in the context of a supportive and effective physician-patient relationship." [21] (p. 133)

The proponents of this perspective define integrative health care as care that considers the whole person as an unique and integrated individual comprised of several dimensions including physical, psychological, spiritual, social and even cosmological aspects. [21,26,27] The health of the individual depends on the relative balance, harmony, and integration of each of these dimensions, while at the same time being influenced by the health of the society and physical environs in which the person lives. [28] Not surprisingly, then, the cause of disease is described as multifactorial, and so, too, is the treatment that follows. Since the diagnosis and treatment can involve any dimension or variety of these factors, [26] the treatment plan designed by the patient and the practitioner invariably considers issues that extend beyond the presenting complaint and/or the typical diagnostic categories of conventional medicine. [21]

Accordingly, they place the dominant focus of integrative health care on the wellness and healing of the person rathe · than the symptoms and curing of a disease. In this approach, healing of the patient may be possible even when the cure of a disease is not. [29] The practitioner also recognizes the intrinsic or innate healing properties already operative within the person and seeks to assist these rather than ignore or supplant them. [21,24] Consequently, there is an emphasis on the role and responsibility of the patient for her/his own health, as well as a need to include patient participation, preferences and self-knowledge when designing any treatment plan. [28,30] Therefore, patient-centred care is a foundational tenet in integrative health care. [21,26]

In this perspective of integrative health care, the influences on an individual's health include factors beyond personal being and societal structures. They might include ecosystem health [31-33] and more cosmic factors such as *chi* energy or *prana*. [34,35] This is an understanding of health that broadens that notion to include influences that do not depend solely on the person or human society. In this revised worldview, the illness that a person experiences might be viewed as the body's effort to restore the person to a healthier state of being. Thus, illness and health are both part of the emergence of the individual within a specific environment in a way that seeks to engage the creative tensions of living and promotes the fuller realization of the person. Illness and symptoms might become opportunities for learning and personal growth. The goal of a therapeutic interve ntion is to assist this personal emergence, and if treatment is necessary, it is directed at the cause of the disease rather than the symptoms that manifest. [21,27]

Structure

> *An 'integrative' model of care is interdisciplinary whereby biomedical and other therapies outside its boundaries work together in non-hierarchical ways for the good of the patient.* [36] (p. 233)

Definitions of integrative health care that focus on structure consider the constituent elements and the infrastructure that holds these together. While some commentators contend that integrative ***medicine*** "selectively incorporates elements of complementary and alternative medicine into comprehensive treatment plans alongside solidly orthodox methods of diagnosis and treatment," [26] it can be argued that integrative ***health care*** does more. (p. 119) As Schroeder notes, integrative health care blends both CAHC and conventional medicine in a non-hierarchical manner to arrive at the best treatment plan to promote the health of the patient. [36] Since the former resembles what Caspi has described as a "cut and paste approach" to the delivery of patient care or a form of assimilation, he concludes that such co-optation or "combination medicine is not integrated medicine." [25] For this reason, Caspi rejects the notion that an increase in complementary/alternative medicine courses at medical schools represents a move toward integrative health care. [37]

The National Network of Libraries of Medicine website also provides examples of definitions that reflect the structure theme. It describes integrative health care as

> a collaborative, team care approach between a variety of Western medical, traditional and indigenous, and CAM licensed health care providers. It implies a comprehensive access to a full range of health care systems based on patient need and cost effectiveness. [38]

This team care approach can operate according to different forms with each form resulting in a somewhat different pattern of integration. For example, Conrad notes that horizontal integration "involves the affiliation of organizations that provide a similar level of care under one management umbrella," while vertical integration "involves affiliation of organizations providing different levels of care under one management umbrella." [39]

Marriott and Mable have provided a broad description of the players who would comprise such a team. They also describe the interactions among the players and the goals of integrative health care. They begin by recognizing that the team players would not only include conventional and CAHC practitioners, but would also "involve and be representative of the individuals and communities served." [40] (p.293) Such inclusivity would undoubtedly be premised on the public having access to quality information about their health options and any assistance that they might require to navigate this information. [28]

Marriott and Mable go on to note that an integrative health care system

> would integrate a continuum of services encompassing health promotion, disease prevention, wellness, and health maintenance, into community-based, facility-based and specialized institutional forms of care. Public funding would be population-based and designed to provide flexibility in how it meets the needs of different populations. Effectiveness of planning and management would be

enhanced by commitment to evidence-based practice, needs assessment and evaluation. It would foster collaboration between professionals and communities as well as between health and other sectors, to realign professional perspectives to support the goals of reform. [40] (p.293)

Process

'Integration' has been used interchangeably with 'coordination of care' or been defined as the process of creating a "seamless" system of care for patients. [41] (p. 42)

A third grouping of the definitions that describe integrative health care tends to focus on the internal dynamics of that integration—i.e., the processes involved and how they work or attempt to work. Way *et al* describe integrative health care as "an inter-professional process for communication and decision making that enables the separated and shared knowledge and skills of care providers to synergistically influence the client/patient care provided." [42] (p. 3) As a result of a collaborative process that permits each provider to contribute to the final integrated plan of management—a plan that is derived and accepted through a consensus process—the contributions from each discipline synergistically combine to provide the patient with a level of care that exceeds the collective impact of the individual practices. In other words, integrative health care permits 1 plus 1 to equal 3 rather than merely 2. [21,42]

For such synergism to occur, the various providers must work collaboratively, interdependently, with mutual respect and trust, and with an appreciable understanding of each other's perspectives and abilities. [43-45] The particular skills and knowledge that each member of the team brings to the collaborative interaction—including those of the patient—contribute to the decisions, plans, implementation and outcomes of the health care intervention; similarly, each shares in the responsibilities, burdens and rewards. The competence, confidence, knowledge and insights of each contributor coalesce in a synergistic collaboration that promises the best and potentially most comprehensive care for the patient. [46]

Ray examines how that synergistic collaboration might come about by comparing unidisciplinary, multidisciplinary, interdisciplinary and transdisciplinary practices. While an unidisciplinary practice has a single practitioner operating in isolation from other providers, a multidisciplinary practice "refers to a clinical group whose members each practice with an awareness and toleration of other disciplines." 47(p. 1370) The various practitioners in a multidisciplinary practice communicate with each other through varying degrees of contact while nevertheless primarily practising within their respective silos. It is even possible that the disciplines involved in a multidisciplinary model would not extend beyond the boundaries of conventional medicine, but would only include sub-disciplines within that larger umbrella (e.g., medical specialists collaborating with a family physician, or various dental specialties collaborating with a dentist).48 Treatment decisions tend to be made by one individual in a multidisciplinary practice, often after consultation with the other members of the ad hoc team.

An interdisciplinary practice, on the other hand, tends to support greater integration of care as the members of the clinical team deliberately coordinate their services across their various disciplines. Echoing the non-hierarchical structure described above, Ray contends that, "In an ideal interdisciplinary health care team, decisions are made by consensus and each discipline has an equal opportunity for input into decisions." [47](p. 1369) The membership of the interdisciplinary team would vary according to the needs of the patient and the care required. Interdisciplinary care is better able to meet the complex health care needs of patients than can any one practitioner since it draws from any variety of health care professions. [47] For the interdisciplinary team of providers to functional in a truly integrative manner, however, they must share a common understanding of health and patient care, and be dedicated to operationalizing those principles as they share expertise and information in a collaborative and respectful manner.

Fourthly, Ray describes transdisciplinary practice as

> team members from different disciplines who share knowledge and skills; as a result, the traditional boundaries between professions become less rigid, allowing members of the team to work on problems not typically encountered by or seen as the responsibility of their discipline. [47](p. 1371)

Both a transdisciplinary practice and an interdisciplinary practice can become examples of integrative health care depending on how effectively the process of integration is operating.

For integrative health care to be successful, practitioners who have been trained to work autonomously will need to adopt and develop skills of cooperation and collaboration. Miles has provided a quaint metaphor to describe the shift in mind-set that is required.

> Now, there is a growing movement toward 'integral' or collaborative practice models, attempting to bring together in a cooperative fashion a spectrum of practice approaches. We are asking the eagles to join in flocks, and like a family of cooperative geese, fly together to arrive at a mutually desired destination: An improved patient. [49] (p. 57)

The result will be a seamless, continuum of quality care for the patient [41,50] provided by collaborative and reflective practitioners who will strive to ensure that [the] new methods are safe, effective and acceptable to patients. [28]

Even in the midst of this cooperative, collaborative, consensus building, practitioners can and must be able to function with autonomy and independence. While each practitioner of the integrative health care team has agreed to a specific plan of management for a particular patient, the implementation of that plan requires professionals who apply their skills, knowledge and good sense in the day-to-day care of the patient. If each decision were to be reviewed by the entire team, then inertia would ensue and patient care would deteriorate. Most of the practitioners would also be governed by the regulations of their professions and would be functioning within that respective scope of practice. Therefore, the mutual trust and respect that underscore integrative health care do not only apply to the processes of decision-making but they also extend to the daily tasks of patient care. [42]

Working Definition for Integrative Health Care

Having reviewed various discussions concerning the integration of conventional and CAHC, it is possible to summarize the main themes within those deliberations and to formulate a working definition for integrative health care. As previously mentioned, authors typically define integrative health care by focusing on one (or more) of three themes: 1) philosophy and/or values; 2) structure; and 3) process. (Elements from each of these three themes are summarized below in Table 2.) Although it has been necessary to examine each of these themes in isolation, they are often inter-related and overlapping, and any comprehensive understanding of integrative health care would necessarily involve a mixture of all themes.

Therefore, what are arguably the most significant elements from each theme will be incorporated into a working definition. It is not intended that this definition will be ideal, all-inclusive, and/or accepted by all; the still-evolving and diverse nature of integrative health care precludes such a possibility. It is hoped, however, that the definition will garner wide acceptance and help to bring greater clarity and rigor both to current discussions on integrative health care and the development and evaluation of models for integrative health care delivery. The following definition will be discussed during the first day of the Workshop.

Working Definition

Integrative health care

- seeks, through a partnership of patient and practitioner, to treat the whole person, to assist the innate healing properties of each person, and to promote health and wellness as well as the prevention of disease (philosophy and/or values);
- is an interdisciplinary, non-hierarchical blending of both conventional medicine and complementary and alternative health care that provides a seamless continuum of decision-making and patient-centred care and support (structure);
- employs a collaborative team approach guided by consensus building, mutual respect, and a shared vision of health care that permits each practitioner and the patient to contribute their particular knowledge and skills within the context of a shared, synergistically charged plan of care (process).

Table 2: Elements of Integrative Health Care: A Summary

ELEMENTS OF INTEGRATIVE HEALTH CARE: A SUMMARY		
Philosophy &/or values: describes an underlying worldview or set of values that guide the emergence of integrative health care	**Structure:** describes the constituent elements and the infrastructure that links them together	**Process:** describes the unique process of interaction between the patients and practitioners involved—i.e., the internal dynamics of the integration.
• treat the whole person –body, mind, spirit, social, environmental	• non-hierarchical integration of conventional & CAHC	• separate and shared knowledge and skills synergistically combined
• human health is part of ecosystem health	• collaborative team approach involving both practitioners and the individuals and communities served	• interdisciplinary communication and decision making that is respectful of unique contributions
• focus on health and healing rather than disease and cure	• publicly funded, population-based, flexible	• patient participates in review of information and decision making
• respect and work with the intrinsic healing powers of the body	• provides comprehensive access to a full range of conventional & CAHC care	• integrated plan of management derived & accepted through consensus model
• prefer health promotion and disease prevention to treatment of disease	•	• decisions tend to be made by consensus, involving all disciplines equally
• emphasize importance of lifestyle in creation of health		• public access to quality information about health options
• treat the cause not the symptoms of disease		• sharing of responsibilities, accountability & rewards among practitioners & patient
• disease and health can be part of the emergence of a person		• needs assessment and on-going evaluation
• partnership of patient and practitioner		• coordinated continuum of care / a seamless continuum of quality patient care
• illness is the body's attempt at self-healing		
• commitment to evidence-based practice		

OUTCOMES

In addition to themes of philosophy/values, structure and process, the literature proposes outcomes that would result when an integrative health care system is operational. In a general sense, outcomes are all of the possible products or results that might occur when a particular programme or approach is used. While intended or expected outcomes do not always match actual outcomes, health care treatments or approaches are more likely to be considered successful when they do. Since the most important outcomes can vary by stakeholder groups or subgroups, it is always important to identify the target population.

Outcomes may be identified at the integrative health care system level. For example, a common expectation of an integrative health care system is that it will result in high quality care that is more effective and more cost-effective than care provided as part of the current conventional medical system.[26,28,48,51] When integrative health care is optimal, it is thought that the various therapies will synergistically provide a level of care that exceeds the collective effect of the individual practices.[21,42]

Outcomes may also describe expectations that fall into one of the three theme areas already explored: philosophy/ values; structure; and process. A quick glance at Table 2 will show that the elements of the three identified themes are often not only representative of each theme, but can also describe a favourable outcome. For instance, "health promotion and disease prevention" is a trait that commonly appears in philosophical discussions of integrative health care, it is also an outcome that one would hope to observe if a health care system is operating in an integrative fashion. Similarly, "a collaborative team approach involving both practitioners and the individual and communities served" describes the structure of an integrative health care approach, while at the same time identifying the outcome desired.

Indicators

At the most simplistic level, outcomes are measured or assessed by indicators. Indicators are observable and assessable items that permit us to recognize and evaluate the reality of a particular attribute, trait or process—i.e., the outcome —in the situation under study. Consequently, indicators can be used to inform and/or trigger decision-making. Given the variety of potential outcomes, indicators must be comparably diverse and frequently deal in probability rather than certainty. They may be either quantitative or qualitative. To be effective, indicators must provide reasonable, useful, and meaningful measures of the outcomes under consideration. They must be sufficiently adaptive to measure such diverse factors as productivity, quality, timeliness, efficacy and cost effectiveness.

When indicators are used to evaluate performance (e.g., cost, time, resources, energy expenditure, and financial considerations), the measurements might be affected by several factors, including the validity and reliability of the particular indicators. Consequently, under certain circumstances, indicators might only be able to provide approximate evaluations of outcomes.

A variety of authors have identified indicators that suggest that integrative health care is being provided or at least is emerging within the health care system. Some of these indicators are summarized below in Table 3 and more will undoubtedly emerge during discussions in the workshop. Although six levels of integration are considered in the table, for the purposes of this workshop our focus will primarily be on the practitioner and clinical levels. Nevertheless, since the other levels remain part of the general context of integrative health care, we maintain an underlying interest in discerning and acknowledging the interrelationship of all levels.

Barriers that have traditionally slowed or prevented the introduction of integrative health care can also be identified. The absence of these barriers can be another indicator that integration is occurring. Therefore, potential barriers to integrative health care are also described since they can be used to sharpen an assessment of the level of integration that is occurring. These barriers are summarized in Appendix A.

Having indicators that assess outcomes will permit the assessment of various practices of health care in order to determine if integration is actually occurring, and whether or not one form of health care has any benefit over another. A goal of the workshop is to build upon the literature reviewed here to identify and recommend indicators for assessing integrative health care.

Table 3: Indicators of Successful Integration at various levels in the continuum of care [10,12,52-55]

INDICATORS OF SUCCESSFUL INTEGRATION
Patients / Consumers Level
• do not have to provide successive practitioners with their complete medical file
• test results are shared among practitioners thereby reducing replication
• via the dissemination of information through the system, each practitioner involved in their care is kept abreast of medical events in the patients' lives
• provision of services are not delayed due to limited capacity at successive levels of care
• choices are informed by clear, accurate, contemporary and accessible information
• single portal of access to any service in the system
• experience patient centred care that o deliberately optimizes their autonomy o actively involves them in significant decisions o favours disease prevention and health promotion
• have access to a diversity of practitioners and treatments options
• receive the information and support that they require so that they can become effective participants in their own care
• financial barriers are not a significant determinant of whom can access CAHC
Practitioner Level
• all practitioners in an interdisciplinary practice are involved in deciding fiscal issues
• fiscal policies help to make CAHC therapies accessible to patients
• financial incentives bring CAHC practitioners into the interdisciplinary system
• CAHC practitioners have access to and make use of the facilities & services of the health care system
• all practitioners use the same billing system and administrative service rather than each relying on their own
• CAHC practitioners participate in policy formation and governance
• all practitioners can advocate for quality patient care
Clinical Level
• the most appropriate treatment is preferred whether it is conventional or CAHC
• CAHC is integrated into practice guidelines and algorithms for medical decision making
• evidence that supports the use of CAHC is disseminated among all practitioners
• consensus processes decide clinical protocols and patient care
• CAHC is not relegated to a role of "when all else fails"
• CAHC is regularly included in outcomes data for the system and CAHC practitioners participate in the design of relevant outcome measures
• CAHC is tracked for efficacy, cost effectiveness, use, and additive costs vs. replaced costs
• CAHC delivery is evaluated by benchmarks appropriate to its disciplines
• CAHC practitioners are as comparably trained and experienced as conventional medical staff

Institutional Level
• all aspects of patient care—conventional and CAHC—are supported equitably
• CAHC is viewed as integral to the mission, goal, and action plan of the institution
• wellness care, health promotion, and disease prevention are included in programmes in a truly integrative and interdisciplinary way
• administrative and clinical leaders are committed to the effective inclusion of CAHC
• CAHC is fully integrated into the system's information management
• patient-centred data is retrieved across a continuum of care
• quality improvement programmes include CAHC clinical activities
• there is system-wide education of conventional clinicians about appropriate CAHC referrals
• CAHC practitioners are trained concerning procedures, protocols and appropriateness of referrals to conventional practitioners
• marketing staff are informed of the benefits of CAHC and integrative health care
• integrative health care is marketed by the system
Regulatory Level
• cross-disciplinary co-operation is not only permitted but encouraged whenever it will benefit patient care
• professional liability insurance includes the provision of CAHC therapies
• regulations governing health professions tend to focus more upon controlled acts than on providing control of "scope of practice turf" to specific professions
Policy and Systems Level
• third party payers—whether government or insurance companies—include coverage of valid CAHC therapies and regulated CAHC professions
• research funding is provided to demonstrate the effectiveness and cost effectiveness of CAHC
• policy makers and system administrators are knowledgeable concerning CAHC

Workshop on Integrative Health Care

On the first day of the workshop to be held in Toronto on November 17-18, 2002, participants will hear four presentations that describe existing models of integrative health care operational in the UK, USA, China and Canada. There will be a review of this background paper, and an opportunity for participants to discuss the various models of integrative health care presently operational in different parts of the world. Drawing on this information and their own research and experience, the participants will discuss, critique and re-work the working definition for integrative health care proposed in this background document.

On the second day, the participants will consider the outcomes that would result when integrative health care is achieved, and the indicators by which these outcomes can be assessed.

APPENDIX A

Table 4: Barriers to Integrative Health Care according to Tataryn and Verhoef [10]

BARRIERS TO INTEGRATIVE HEALTH CARE
Consumer Level
• limited financial and educational resources
• biases and limited knowledge concerning CAHC
• limited accessibility to qualified, properly trained and appropriate CAHC practitioners
Practitioner Level
• limited ability of patients to pay for services rendered or natural health products prescribed
• limited research to evaluate efficacy & cost effectiveness of CAHC therapies
• issues of safety and accountability and legal liability
• restrictions or exclusions imposed by regulatory bodies
• resistance by colleagues or professionals with whom practitioner consults
Clinical Level
• multiple and even conflicting paradigms of health, patient care and service delivery
• costly and time-consuming evaluation of programmes that are continuing to evolve
• limited funding for care or research
• limited research to evaluate efficacy & cost effectiveness of CAHC therapies
• resistance from conventional health care system including 3rd party payers
Institutional Level
• current pressures on micro & macro allocation of limited resources
• CAHC seen as additive to costs rather than cost saving
• over worked employees resist introduction of new level of care
Regulatory Level
• many CAHC professions are not regulated or only regulated in some jurisdictions
• concern for "loss of turf" or "loss of identity"
• competition in a fiscally tight medical market
Policy and System Level
• CAHC seen as additive to costs rather than cost saving
• limited research to evaluate efficacy & cost effectiveness of CAHC therapies
• biases & limited knowledge about CAHC among policy makers and system administrators
• issues of safety, accountability, legal liability, regulation, standards of care, product safety and quality assurance
• bureaucratic resistance to change
• political influence

BIBLIOGRAPHY

1. Eisenberg DM, Davis RB, Ettner SL, Appel S, Wilkey S, Van Rompay M, Kessler RC. Trends in alternative medicine use in the United States, 1990-1997: results of a follow-up national survey. Jama. 1998;280:1569-1575

2. Buske L. Popularity of alternative health care providers continues to grow. Cmaj. 2002;166:366

3. McClennon-Leong J, Kerr JR. Alternative health care options in Canada. Can Nurse. 1999;95:26-30

4. Millar WJ. Use of alternative health care practitioners by Canadians. Can J Public Health. 1997;88:154-158

5. Bausell RB, Lee WL, Berman BM. Demographic and health-related correlates to visits to complementary and alternative medical providers. Med Care. 2001;39:190-196

6. Veeramah EK, Holmes S. Complementary therapy: complement or threat to modern medicine? J R Soc Health. 2000;120:42-46

7. Muhajarine N, Neudorf C, Martin K. Concurrent consultations with physicians and providers of alternative care: results from a population-based study. Can J Public Health. 2000;91:449-453

8. Clark PA. The ethics of alternative medicine therapies. J Public Health Policy. 2000;21:447-470

9. Cassileth BR. Complementary therapies: overview and state of the art. Cancer Nurs. 1999;22:85-90

10. Tataryn DJ, Verhoef MJ. Combining Conventional, Complementary, and Alternative Health Care: A Vision of Integration. Perspectives on Complementary and Alternative Health Care. Ottawa: Health Canada; 2001:87-109

11. Eisenberg DM, Kessler RC, Van Rompay MI, Kaptchuk TJ, Wilkey SA, Appel S, Davis RB. Perceptions about complementary therapies relative to conventional therapies among adults who use both: results from a national survey. Ann Intern Med. 2001;135:344-351

12. Bruyn Td. Taking Stock: Policy Issues Associated with Complementary and Alternative Health Care. Perspectives on Complementary and Alternative Health Care. Ottawa: Health Canada; 2001:17-39

13. Achilles R. Defining Complementary and Alternative Health Care. Perspectives on Complementary and Alternative Health Care. Ottawa: Health Canada; 2001:1-15

14. House of Lords. Science and Technology - Sixth Report. London: House of Lords; 2000

15. York University Centre for Health Studies. Complementary and Alternative Health Practices and Therapies. Toronto: York University; 1999

16. Balon JW, Best A, Kelner M, al e. Towards An Integrative Health System: A Discussion Paper from the Advisory Group on Complementary and Alternative Health Care. Ottawa: Health Systems Division, Health Policy and Communications Branch, Health Canada; 2000:10

17. Cherkin D. AMA policy on chiropractic. Am J Public Health. 1989;79:1569-1570

18. Cohen MH, Eisenberg DM. Potential physician malpractice liability associated with complementary and integrative medical therapies. Ann Intern Med. 2002;136:596-603

19. Meeker WC. Framing Integration in the Chiropractic Community. Davenport; 2002:8

20. Meeker WC. "Integration" -- The New Buzzword. Vol. 2002: ChiroWeb.com; 2002

21. Bell IR, Caspi O, Schwartz GE, Grant KL, Gaudet TW, Rychener D, Maizes V, Weil A. Integrative medicine and systemic outcomes research: issues in the emergence of a new model for primary health care. Arch Intern Med. 2002;162:133-140

22. Berg B. Qualitative Research Methods for the Social Sciences (ed 2nd). Needham Heights, Mass.: Allyn And bacon; 1995

23. Morse J, Field P. Qualitative Research Methods for Health Professionals (ed 2nd). London: Sage; 1995

24. Gaudet TW. Integrative Medicine: The Evolution of a New Approach to Medicine and to Medical Education. Integrative Medicine. 1998;1:67-73

25. Caspi O. Integrated medicine: orthodox meets alternative. Bringing complementary and alternative medicine (CAM) into mainstream is not integration. Bmj. 2001;322:168

26. Rees L, Weil A. Integrated medicine. Bmj. 2001;322:119-120

27. Weil A. The significance of integrative medicine for the future of medical education. Am J Med. 2000;108:441-443

28. Coates JR, Jobst KA. Integrated healthcare: a way forward for the next five years? A discussion document from the Prince of Wales's Initiative on Integrated Medicine. J Altern Complement Med. 1998;4:209-247

29. Reilly D. Enhancing human healing. BMJ. 2001;322:120-121

30. Maizes V, Caspi O. The principles and challenges of integrative medicine. West J Med. 1999;171:148-149

31. Tong S. The potential impact of global environmental change on population health. Aust N Z J Med. 2000;30:618-625

32. Amaral-Mendes JJ, Pauluis J. Environmental health and the family doctors. Cent Eur J Public Health. 1999;7:203-206

33. Pedersen D. Disease ecology at a crossroads: man-made environments, human rights and perpetual development utopias. Soc Sci Med. 1996;43:745-758

34. Chen YC. Chinese values, health and nursing. J Adv Nurs. 2001;36:270-273

35. Mahdihassan S. A comparative study of Chinese cosmology cum-humorology with eight elements. Am J Chin Med. 1990;18:181-184

36. Schroeder CA, Likkel J. Integrative health care: the revolution is upon us. Public Health Nurs. 1999;16:233-234

37. Caspi O, Bell IR, Rychener D, Gaudet TW, Weil AT. The Tower of Babel: communication and medicine: An essay on medical education and complementary-alternative medicine. Arch Intern Med. 2000;160:3193-3195

38. Terminology. Vol. 2002: National Network of Libraries of Medicine; 2000

39. Conrad DA, Shortell SM. Integrated Health Systems: Promise and Performance. Frontiers of Health Services Management. 1996;13:3-40

40. Marriott J, Mable AL. Integration: follow your instincts, ignore the politics, and keep your eyes on the ideal model. Can J Public Health. 1998;89:293-296, 314

41. Graham W. Moving Healthcare Reform Forward: A Complex and Challenging Transition. Healthcare Papers. 1999;1

42. Way D, Jones L, Busing N. Implementation Strategies: "Collaboration in Primary Care - Family Doctors & Nurse Practitioners Delivering Shared Care". Toronto: The Ontario College of Family Physicians; 2000:1-11

43. Meeker WC. Public demand and the integration of complementary and alternative medicine in the US health care system. J Manipulative Physiol Ther. 2000;23:123-126

44. Peters D, Chaitow L. Integrating Complementary Therapies in Primary Care: A Practical Guide for Health Professionals. Toronto: Churchill Livingstone; 2002

45. Neale J. Practitioners and Physicians: A Collaborative Practice. Clinical Nurse Specialist. 1999;13:252-258

46. Wells N, Johnson R, Salyer S. Interdisciplinary Collaboration. Clinical Nurse Specialist. 1998;12:161-168

47. Ray MD. Shared Borders: Achieving the Goals of Interdisciplinary Patient Care. American Journal of Health-System Pharmacy. 1998;55:1369-1374

48. Kaplan E. What You Should Know. American Chiropractor. 1998;20:32

49. Miles R. Organizing Collaborative Practices. Alternative Health Practitioner. 1998;4:57

50. Warren ML, Houston S, Luquire R. Collaborative Practice Teams: From Multidisciplinary to Interdisciplinary. Outcomes Management for Nursing Practice. 1998;2:95-98

51. Ephraim R. Integrative Medicine. Journal of Ecology & Natural Living. 2000;13:24-25

52. Simpson C, Faass N. Criteria for Assessing Successful Integration. In: Faass N, ed. Integrating Complementary Medicine into Health Systems. Maryland: Aspen Publishers, Inc.; 2001:276-282

53. Leatt P, Pink GH, Guerriere M. Towards a Canadian Model of Integrated Healthcare. HealthcarePapers. 2000;1:13-35

54. Best A, Glik D. Research as a Tool for Integrative Health Services Reform. In: Kelner M, Wellman B, Pescolido B, Saks M, eds. Complementary and Alternative Medicine: Challenge and Change. Amsterdam: Hardwood Academic Publishers; 2000:239-254

55. Bodeker G. Lessons on integration from the developing world's experience. Bmj. 2001;322:164-167

Appendix B:

Workshop Agenda

Integrative Health Care Workshop

AGENDA

Location: Metropolitan Hotel, Toronto

Sunday November 17, 2002

Objective: To achieve consensus on a working definition of integrative health care that will be used for this workshop.

8:30-9:00	Continental Breakfast
9:00-9:10	Welcome and Review of the Workshop Objectives/Agenda (Heather Boon)
9:10-9:30	Introductions of participants
9:30-10:00	Integrative Health Care in Action Model #1 (David Peters, UK)
10:00-10:30	Integrative Health Care in Action Model #2 (Richard Leibowitz, USA)
10:30-10:50	BREAK
10:50-11:20	Integrative Health Care in Action Model #3 (Xu Xuwei, China)
11:20-11:50	Integrative Health Care in Action Model #4 (Barbara Findlay, Canada)
11:50-12:30	Facilitated Plenary Discussion (Theo de Bruyn) Topic: Integrative Health Care in Action – Similarities and Differences
12:30-1:30	LUNCH
1:30-1:45	Background paper review (Heather Boon)
1:45 –2:30	Definition Serial Round 1 (Philosophy)
2:30 – 3:15	Definition Serial Round 2 (Structure)
3:15 – 3:45	BREAK
3:45 – 4:30	Definition Serial Round 3 (Process)
4:30 – 4:45	Plenary wrap-up & evaluation

Integrative Health Care Workshop

AGENDA

Monday November 18, 2002

Objective: To provide recommendations for how one might assess integrative health care.

8:30-9:00	Continental Breakfast
9:00-9:15	Review of work from previous day and review of Agenda for second day (Theo de Bruyn)
9:15 – 9:45	Plenary Discussion of "Outcomes"
9:45 – 11:10	Small working groups to discuss potential outcomes of integrative health care
11:10 – 11:30	BREAK
11:30 – 12:30	Report back and discussion
12:30 – 1:30	LUNCH (Synthesis by planning team over lunch)
1:30 – 1:50	Synthesis feedback to participants (Theo de Bruyn)
1:50 - 3:20	Small working groups to discuss indicators of integrative health care and specific tools/techniques for assessing these indicators
3:20 – 3:40	BREAK
3:40 – 4:30	Report back and discussion
4:30 – 5:00	Where do we go from here?
5:00	Workshop ends

Appendix C:

Final Report from the Workshop

Integrative Health Care:
Defining and Operationalizing the Fundamental Elements

Workshop Report
November 17-18, 2002

Prepared by: Theodore de Bruyn
January 2003

Funding for this event was provided by the Health Policy Research Program (Health Canada)

For Additional Information Contact:

Heather Boon, PhD
Faculty of Pharmacy, University of Toronto
19 Russell Street
Toronto, ON
Canada M5S 2S2
Email: heather.boon@utoronto.ca

Table of Contents

Executive Summary	32
Introduction	33
Four Models of Integrative Health Care	34
Definition of Integrated Health Care	35
Outcomes and Indicators at the Clinical and Practitioner Level	37
Next Steps	42

Integrative Health Care:
Defining and Operationalizing the Fundamental Elements
Workshop Report
November 17-18, 2002

Executive Summary

The workshop on Integrative Health Care: Defining and Operationalizing the Fundamental Elements was convened with the following objectives:

- to achieve consensus on a working definition of integrative health care; and
- to identify outcomes and indicators of integrative health care at the clinical and practitioner level.

Funding for the workshop was provided by the Health Policy Research Program, Health Canada.

The participants at the workshop were drawn from Canada, the United States, the United Kingdom, and China. Presentations were made on the clinical practice of integrative health care at four centres: Marylebone Health Centre, London, United Kingdom; the Duke Center for Integrative Medicine, North Carolina, United States; Shanghai Yueyang Hospital, Shanghai, China; and the Tzu Chi Institute, Vancouver, Canada.

Prior to the workshop the organizers prepared a background paper reviewing the existing literature on the definition of integrative health care and proposing a working definition based on the philosophy and/or values of care, the structure of care, and the process of care. Participants discussed the definition of integrative health care put forward in the background paper, and agreed upon a set of components of integrative health care to serve as the basis for the discussion of outcomes and indicators for the duration of the workshop.

Integrative health care, as described by the participants:

- takes a person-centred, person-empowering approach to health care;
- recognizes inter-relationships among physical, mental, social, environmental, and spiritual dimensions of health and well-being;
- facilitates healing;
- allows for and considers multiple disciplines and modalities;
- requires inter-disciplinary and inter-professional working relationships among practitioners;
- provides access to and support for needed or desired care at the health systems level;
- supports continuity and coordination in care;
- incorporates a process of organizational (professional, clinical, institutional, systems-level) development, reflection, and evaluation on activities, process, and outcomes of care.

Participants identified outcomes and indicators for each of these components of integrative health care as experienced and practised at the clinical and practitioner level.

Integrative Health Care:

Defining and Operationalizing the Fundamental Elements
Workshop Report
November 17-18, 2002

Introduction

The increasing use of complementary and alternative health care (CAHC) in North America has necessarily raised questions and concerns about the interaction between CAHC and conventional medicine. While conventional medicine increases its efforts to integrate the delivery of health care services within its own therapeutic disciplines with such initiatives as multi-disciplinary clinics and case managers, the potential integration of conventional medicine with CAHC has received little attention. Consequently, the interplay between the two could be typified more by a fragmentation of services rather than by a beneficial synergy. When this concern has been addressed, there appears to be little consistency in the framing of the issue. Different centres, clinicians, and researchers seem to have varying definitions for the integration of CAHC with conventional medicine. Accordingly, it is not only difficult to address this matter on a more global level, it is also difficult to assess when integrative medicine is actually happening.

The workshop on Integrative Health Care: Defining and Operationalizing the Fundamental Elements was convened with the following objectives:

- to achieve consensus on a working definition of integrative health care; and
- to identify outcomes and indicators of integrative health care at the clinical and practitioner level.

A definition of integrative health care that garners wide acceptance will facilitate research involving CAHC and conventional medicine, as well as the continuing evolution of the integration of these two. It will provide a context for intelligible dialogue in policy and practice. Outcomes and indicators of integrative health care at the clinical and practitioner level will provide the tools with which to identify when and where integrative health care occurs, to assess the effectiveness of different approaches to integrative health care, and to improve the delivery of integrative health care.

The Workshop was organized by Heather Boon, Faculty of Pharmacy, University of Toronto, in collaboration with Marja Verhoef, Department of Community Health Sciences, Faculty of Medicine, University of Calgary; Barbara Findley, Tzu Chi Institute for Complementary and Alternative Medicine, Vancouver; and Dennis Patrick O'Hara, Elliott Allen Institute for Theology and Ecology, University of St. Michael's College, Toronto. The invited participants were drawn from Canada, the United States, the United Kingdom, and China (see Appendix D for a list of participants).

Funding for the workshop was generously provided by the Health Policy Research Program, Health Canada.

Four Models of Integrative Health Care

Description of the four models

The workshop opened with presentations on the clinical practice of integrative health care at the Marylebone Health Centre, London, United Kingdom; the Duke Center for Integrative Medicine, North Carolina, United States; Shanghai Yueyang Hospital, Shanghai, China; and the Tzu Chi Institute, Vancouver, Canada.

The Marylebone Health Centre provides a full range of primary care services under the National Health Service and an expanded range of complementary services, including counselling, massage, homeopathy, acupuncture, osteopathy, and naturopathy. The Centre maintains that because people are complex and self-organizing, integration is more than simply combining conventional and complementary approaches. It calls for practitioners to collaborate and learn from one another and from their patients in order to improve outcomes. To this end the Centre has adopted a reflexive approach to governance. This entails a cycle of practice review, resource assessment, service design, service delivery, service assessment, and service modification.

The Duke Center for Integrative Medicine opened its clinic in December 2000. It is a consulting clinic, not a primary care clinic. Practitioners affiliated with the clinic include a practitioner of family medicine/acupuncturist, a specialist in general internal medicine, an obstetrician/gynecologist, a radiologist/acupuncturist, a psychiatrist, a physician's assistant, and a health psychologist. Referrals are made to alternative practitioners in the community. Credentialed services include licensed acupuncturists, personal wellness coaches, mindfulness-based stress reduction consultants, massage therapy, yoga, and Tai Chi. The approach to consultation and care focuses on helping each patient to develop a strategic health plan and to maintain that plan with the assistance of a personal wellness coach.

Dr. Xu Xuwei presented a personal perspective based on his work as a practitioner of traditional Chinese medicine and a specialist in neurology and neuro-cardio-vascular disease. The practice of health care at Shanghai Yueyang Hospital involves dual diagnosis and dual prescription in both Western medicine and traditional Chinese medicine. However, there is still a substantial gap in theory and practice between the two. Moreover, Western medicine is becoming increasingly more popular than traditional Chinese medicine because people want quicker remedies. Dr. Xuwei's particular interest is in the scientific study of integrative internal medical care (a subset of integrative medical care, which is in turn a subset of integrative health care).

The Tzu Chi Institute, which was founded in 1996, has a three-fold mandate: clinical care, research/evaluation, and education/information. Clients refer themselves to the clinic; 80 percent of them are living with chronic illness. An interdisciplinary team of practitioners works collectively toward outcomes expressed by the client. The team includes a chiropractic doctor, a medical doctor, a naturopathic doctor, a registered nurse, a registered massage therapist, an acupuncturist, a doctor of traditional Chinese medicine,

and practitioners of mind-body therapy and art therapy. An individualized plan of care is developed. Health records are shared, and charting is consecutive, providing a complete picture of the care provided. Sustainability of the program in the absence of government funding for CAHC remains an ongoing concern and challenge.

Similarities and differences in the four models

Participants noted a number of similarities among the four models. Each of the models aims to be true to a particular philosophy and set of values regarding health care. Each takes a patient-centred approach to health care, and considers a broad range of factors or determinants when assessing a patient's health. All of the models are significantly influenced by contextual factors: institutional relations, professional regulations, the physical environment, and funding constraints. In this context, reflective assessment, research, and evaluation are judged to be very important, both to understand and improve the integration of services and to provide the evidence in support of integrative health care.

The models also differed from each other in several aspects. Some of the centres provide services covered by public insurance plans, whereas others provide services that are covered by private insurance plans or paid for out-of-pocket. The former are, in general, more accessible to poorer or under-served populations. The process of initial consultation and assessment – particularly the role of the medical doctor as "gate-opener" to other services – differs in each of the models. The range of services varies, as does the corresponding mix of practitioners. In addition, the inclusion of research/evaluation and education/information in the models' mandate is a major difference. In three of the models, services are co-located at one site; in one, services are available in the community. Some centres have an academic affiliation; others do not. Likewise, the professional recognition of the practitioners providing services varies from centre to centre.

Identification of these similarities and differences led to a discussion of the essence of integrative health care.

Definition of Integrative Health Care

Proposed working definition

Prior to the workshop the organizers prepared a background paper reviewing the existing literature on the definition of integrative health care and proposing a working definition based on the philosophy and/or values of care, the structure of care, and the process of care. As proposed by the organizers, integrative health care:

- seeks, through a partnership of patient and practitioner, to treat the whole person, to assist the innate healing properties of each person, and to promote health and wellness as well as the prevention of disease (philosophy and/or values);

- is an interdisciplinary, non-hierarchical blending of both conventional medicine and complementary and alternative health care that provides a seamless continuum of decision-making and patient-centred care and support (structure); and

- employs a collaborative team approach guided by consensus building, mutual respect, and a shared vision of health care that permits each practitioner and the patient to contribute their particular knowledge and skills within the context of a shared, synergistically charged plan of care (process).

While outcomes were not included in the working definition, their importance was identified and discussed in the background paper.

Discussion

There was a lively debate about the terms of the definition. Some participants felt that the definition was in fact a mission statement or a goal of how integrative health care should be delivered. As such, it did not seem to acknowledge degrees of, or stages in the development of, integrative health care. Several participants also observed that the definition as it stands goes beyond describing components of integrative health care to stating hypotheses about the nature of integrative health care. They urged that the definition should not include implied hypotheses, to avoid possible confusion between evidence contradicting the hypotheses and evidence contradicting the existence of integrative health care.

It was noted that the definition leaves unstated the impetus for or foil to integrative health care, namely, the segregated or specialized divisions of conventional medicine, and its heavy focus on the biomedical aspects of disease. It was suggested that this context should be explained in a preamble to the definition. The preamble should discuss the philosophical bases for proposing an alternative to conventional medicine, and introduce some of the central concepts of this alternative (such as healing, wholeness, well-being, health, and transformation). It should acknowledge the many dimensions of health (physical, mental, social, environmental, and spiritual) that must be taken into consideration, and should explain that integrative health care combines health promotion, disease prevention, and treatment services.

Several participants stressed that the empowerment of the patient is central to integrative health care. Others noted that patients are not always in a position to be engaged in their care.

Finally, participants suggested that, in addition to structure, process, and outcomes of health care, the definition needed to address systems of health care and the delivery and evaluation of health care.

Components of a working definition

The workshop participants agreed on a set of components of integrative health care that would serve as the basis for the discussion of outcomes and indicators for the duration of the workshop.

Integrative health care:

- takes a person-centred, person-empowering approach to health care;
- recognizes inter-relationships among physical, mental, social, environmental, and spiritual dimensions of health and well-being;
- facilitates healing;
- allows for and considers multiple disciplines and modalities;
- requires inter-disciplinary and inter-professional working relationships among practitioners;
- provides access to and support for needed or desired care at the health systems level;
- supports continuity and coordination in care;
- incorporates a process of organizational (professional, clinical, institutional, systems-level) development, reflection, and evaluation on activities, process, and outcomes of care.

Outcomes and Indicators at the Clinical and Practitioner Level

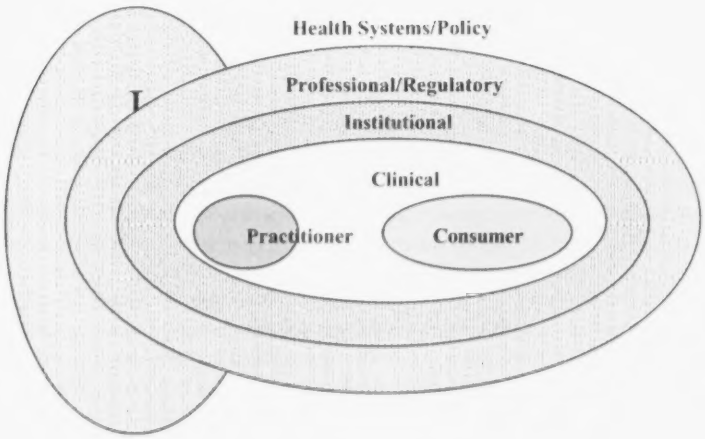
Integration in health care can occur at many levels: at the level of the consumer, practitioner, clinic, institution, professional or regulatory body, and health systems and policy.[1] The workshop primarily focused on outcomes and indicators of integration at the clinical and practitioner level. This level was understood to encompass relations between the practitioner providing care and the person seeking care (see Figure 1).

It was acknowledged that integration at the clinical and practitioner level is influenced in many ways by the institutional, professional, regulatory, systems, and policy contexts. However, for the purposes of the workshop, the focus was on the clinical and practitioner level, while nevertheless allowing for observations about the effects of other levels on integration at the clinical and practitioner level.

The workshop participants divided into three working groups to identify outcomes of integrative health care and, where possible, indicators of these outcomes. Outcomes were defined as *all of the possible products or results that might occur when a particular program or approach is used*. Indicators were defined as *specific items that can be measured or assessed*.

[1] See DJ Tataryn, MJ Verhoef. Combining conventional, complementary, and alternative health care: a vision of integration. In *Perspectives on Complementary and Alternative Health Care*. Ottawa: Minister of Public Works and Governments Services, 2001, VII.87-109, at 97-99.

Figure 1: Levels of Health Care



Person-centred, person-empowering approach to health care

Outcomes of an approach that centres on and empowers the person seeking care might include the following:

- The person senses that their needs are being met and the person has a sense of working in partnership with the practitioner. This could be measured by needs assessments and satisfaction surveys that measure congruence between the person's and the practitioner's goals and perceived outcomes of care.
- The person has a greater sense of responsibility for their health and well-being, as indicated by measures of adherence to a personal health strategy.
- The person has an increased sense of empowerment, as indicated by measures of locus of control and level of self-efficacy.
- The person has an increased sense of meaning in life, as indicated by sense of meaning scales.

Inter-relationships among physical, mental, social, environmental, and spiritual dimensions of health and well-being

Outcomes of an approach that recognizes the inter-relationships among physical, mental, social, environmental, and spiritual dimensions of health and well-being might include the following:

- The approach to care deals with the whole person (body, mind, spirit, social context), as indicated by a review of case notes and by the person's responses to surveys designed to assess psychosocial health and spiritual health.

- The approach to care focuses on health promotion and disease prevention. This could be indicated by the goals, program, informational material, and resource allocation of the health care setting. Over the long term it could be indicated by decreased incidence of disease and use of health services.
- The practitioner involves the person's social system (family, community, culture) in the care process, as indicated by measures of the involvement of others in the person's health care and measures of the direct and buffering effects of social support.
- The person and the practitioner have an increased awareness that human health is part of ecosystem health, as indicated by their responses to a personal environmental assessment and to an empathy scale.
- The person has an increased awareness of self and of the spiritual dimensions of health, and a greater understanding of illness and death as part of living and life (indicators to be determined using one of several spiritual health indices).
- The practitioner has an increased sense of well-being as care-giver, as indicated by measures of quality of life, provider satisfaction, and professional burn-out.
- The person, the practitioner, and their community show evidence of increased health and well-being (indicators to be determined).[2]

Care facilitates healing

Outcomes of care that facilitates healing (which is broader than the treatment of disease) might include the following:

- The person experiences improved quality of life, as indicated by quality of life scales.
- The care process focuses on health and healing rather than disease and treatment, as indicated by the goals, program, informational material, and resource allocation of the health care setting.
- The person has an increased awareness of self, self-efficacy, and personhood as a result of the exploration of the process of illness and health (indicators to be determined).

Access to and utilization of multiple disciplines and modalities

Outcomes of care that incorporates multiple disciplines and modalities might include the following:

- There is a demonstrable pattern of access to conventional and complementary or alternative health care systems, disciplines, and modalities. This could be indicated by the types of systems, disciplines, and modalities that are available; the number of practitioners involved; the physical distance between practitioners; the co-location of services; records of the practitioners consulted, the therapies

[2] Indicators could be derived from models of a comprehensive approach to health such as the international community at Aurorville, India (see www.auroville.org), or the environmental, health, and support programs of Husky Injection Molding Systems (see http://cache.husky.ca/en/pdfs/ehs4.pdf).

used, and the frequency of practitioner consultations and therapeutic interventions; the affordability of care sought or provided; and other measures of access to care. It could also be indicated by practitioners' and persons' awareness of and attitudes toward different systems, disciplines, and modalities.

Inter-disciplinary and inter-professional relationships

Outcomes of care that involves effective inter-disciplinary and inter-professional relationships might include the following:

- There is evidence of inter-disciplinary or inter-professional working relationships among practitioners. This could be indicated by policies, procedures, or habits with regard to communication (mode and frequency), information-sharing, and referrals. It could also be indicated by the nature of the relationship, the degree of autonomy among practitioners, and the arrangement of leadership or authority among practitioners.
- There is a demonstrable culture of respect, shared vision, team approach, consensus, and synergy among practitioners. This could be indicated by the scope and limitations of the practice of different practitioners, the initial assessment process for the person seeking care (method of entry, point of entry, assignment of practitioners' responsibilities, etc.), ongoing case management, and the body of evidence by which these clinical pathways are determined.
- There is a demonstrable pattern of shared decision-making, both among practitioners and with persons seeking care. This could be indicated by several of the measures described in the preceding item, as well as by measures of trust and satisfaction for practitioners and for persons seeking care.

Access to and support for care as desired or needed

Outcomes of systems that are responsive to the expressed desires or needs of the person seeking care might include the following:

- The person's needs are assessed through a collaborative process that considers the accessibility of care, the available resources, the person's beliefs and choices, the practitioner's experience, and the evidence for a given therapy. This could be indicated by the value given to the person's narrative of their situation and needs, as measured by the intake instrument, the record of the narrative in the chart, direct observation of the assessment process, the person's report of the assessment process, and the support given to practitioners to learn about and improve their listening and communication skills.
- Decisions are made with a spectrum of informational supports, including the practitioner's knowledge and experience, the person's knowledge and experience, peers, advocacy groups, health intermediaries, information specialists, literature, and informational databases. This could be indicated by such resources as brochures, websites, access to libraries or resource centres, opportunities for information-sharing, support in accessing information, and the range of

information that is accessed. The process of providing informational support could be measured by direct observation, the person's account as to whether their need for information has been met, and the practitioner's efforts to determine whether the person has understood the information provided.

- Access to care is continually improved by identifying constraints and working to overcome them. This could be indicated by the process for identifying and reviewing unmet needs, decisions to provide new services based on identified needs, the network of referral relationships, and participation in broader policy and regulatory discussions toward resolving barriers to access.

Continuity and coordination in care

Outcomes of efforts to provide continuity and coordination in care might include the following:

- There are structures to enable or enhance communication, learning, and coordinated action. This could be indicated by the presence of a primary contact (e.g., health coach or case manager) that people seeking care can easily identify and access, communication and information-sharing among practitioners on behalf of the person seeking care, and access to clinical notes and diagnostic information for all practitioners.
- There are processes to enable or enhance team-work among practitioners and shared space in providing care (indicators to be determined).
- The care process (case management and clinical pathways) provides evidence that there is a sharing of paradigms with regard to the various levels or aspects of health: biochemical and nutritional, physiological structure and function, psychosocial, sense-making and self-regulation, spiritual, and energe tic (indicators to be determined).

Organizational development, reflection, and evaluation

Outcomes of organizational development, reflection, and evaluation with regard to activities, processes, and outcomes of care might include the following:

- Evidence of reflection, learning, and development with regard to met or unmet needs, the appropriateness of care, the effectiveness of care, risks and safety, and activities for the practitioner and the person seeking care.
- Evidence of development at the professional, clinical, institutional, regulatory, and systems level with regard to the appropriateness, accessibility, acceptability, equity, effectiveness, and efficiency of care (indicators to be determined.)

Next Steps

In addition to preparing this report on the workshop, the organizers will revise the background paper and submit it for publication in a peer-reviewed journal. They will also prepare a second paper discussing the response of the workshop's participants to the background paper and exploring some of the ideas proposed at the workshop in greater detail.

The organizers will be consulting with the participants on other specific steps that could advance the work begun at the workshop. These might include, for example, collecting instruments and scales that could potentially be used to measure indicators of integrative health care.

Appendix D:

Workshop Participants

Participant List
Integrative Health Care:
Defining and Operationalizing the Fundamental Elements
November 17th and 18th, 2002

Planning Team:

Heather Boon – Chair
Faculty of Pharmacy
University of Toronto
19 Russell Street
Toronto, ON
M5S 2S2
Tel: 416-9465859
Fax: 416-9781833
E-mail: heather.boon@utoronto.ca

Heather Boon, BSc Phm, PhD is an Assistant Professor in the Faculty of Pharmacy, University of Toronto. In addition, Dr. Boon is cross-appointed to the Department of Family and Community Medicine and the Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto. Dr. Boon co-authored the textbook The Botanical Pharmacy, and has founded the Toronto Complementary and Alternative Medicine Research Network. Her primary research interests are patients' use of complementary/alternative medicine, the safety and efficacy of natural health products and complementary/alternative medicine regulation and policy issues.

Theodore de Bruyn – workshop facilitator
Research Consultant
167 Belmont Avenue
Ottawa, ON
K1S 0V6
Tel: 613-730-7841
Fax: 613-730-0782
Email: tdebruyn@cyberus.ca

Theodore de Bruyn is a consultant in health policy, based in Ottawa, Canada. In recent years he has worked with Health Canada in consultations on a number of aspects of complementary and alternative health care and natural health products. His work in health policy often involves the synthesis of findings from several fields of research, approaching health and health care from various perspectives. Theodore has a specific expertise in policy in the context of the HIV/AIDS epidemic. He is Managing Editor of the *Canadian HIV/AIDS Policy & Law Review*, and has served as Chair of the National Ethics Review Committee of the Canadian HIV/AIDS Trials Network. Theodore holds a

Ph.D. in theology and taught in that field prior to working in health policy. He maintains a program of research in religious studies.

Barbara Findlay - speaker
Tzu Chi Institute for Complementary & Alternative Medicine
767 West 12th Avenue
4th Floor West
Vancouver, BC, V5Z 1M9
Tel: 604-875-4769
Tel:604-875-5555 ext. 66704 (direct line)
Fax: 604-875-5781
E-mail: bfindlay@tzu-chi.bc.ca
www.tzu-chi.bc.ca

Barb Findlay is the Executive Director of the Tzu Chi Institute for Complementary and Alternative Medicine in Vancouver, B.C., an organization committed to expanding the concept of 'integration' in health care. Her professional background includes 20 years of nursing and education for patients and health professionals in conventional settings. Since joining the Institute in 1997, she has provided leadership for its clinical program development, including the design and implementation of an Integrated Care Program and health outcomes research protocol. From a dual (clinician/researcher) focus, Barb has been involved as co-investigator in designing a number of collaborative randomized, controlled clinical trials and has first-hand experience with some of the methodological challenges in studying CAHC. She is an advocate for combining qualitative and quantitative approaches to research in the field of integrative medicine, and believes that studying process is at least as important as measuring outcomes in new and emerging fields of study such as this one. A frequent presenter on the issues surrounding integrative health care, she has been an active participant in Health Canada's consultation process around CAHC and integrative medicine in Canada.

Dennis Patrick O'Hara
Elliot Allen Institute for Theology & Ecology
University of St. Michael's College
81 St. Mary Street
Toronto, ON
M5S 1J4
Tel: 416-538-7777
Fax: 416-530-1788
E-mail: dennis.ohara@utoronto.ca

Dennis Patrick O'Hara graduated from the Canadian Memorial Chiropractic College in 1979 and the Ontario College of Naturopathic Medicine in 1986, subsequently teaching at both of these colleges while practising as a chiropractor and naturopathic doctor. He attained a Master of Divinity degree in 1992 and a PhD in systematic theology in 1998,

both from the University of St. Michael's College (USMC) at the University of Toronto. He also holds a specialization in theology and ecology awarded conjointly by the Elliott Allen Institute for Theology and Ecology (EAITE) and the USMC. Presently, he is an Assistant Professor of Ethics at USMC, and the director of the EAITE.

Marja J. Verhoef
Department of Community Health Sciences, Faculty of Medicine
University of Calgary
3330 Hospital Drive, NW
Calgary, Alberta
Canada
T2N 4N1
Tel: 403-220-7813
Fax: 403-270-7307
E-mail: mverhoef@ucalgary.ca

Marja Verhoef is a Professor in the Department of Community Health Sciences at the University of Calgary. She is also senior researcher with the Tzu-Chi Institute of Complementary and Alternative Medicine in Vancouver. In 2001 she was awarded a Canada Research Chair in Complementary Medicine. Her research focuses on a wide range of factors related to complementary and alternative medicine, such as determinants of use, decision making, communication, information needs, importance of evidence, integration of CAM with conventional medicine and evaluation of integration models. She has founded the Alberta Complementary and Alternative Medicine Research Network. She is actively involved in developing appropriate methodology to evaluate complementary and alternative therapies and approaches. Since 2000 she is a special advisor with respect to education and research related to complementary and alternative medicine to Health Canada. Her teaching includes courses and workshops on different aspects of quantitative and qualitative research methods, proposal writing and questionnaire development and theory and research of complementary medicine. She has widely published about various aspects regarding complementary and alternative medicine.

Heidi Amernic
Faculty of Pharmacy
University of Toronto
19 Russell Street
Toronto, ON
M5S 2S2
Tel: 416-946-7840
E-mail: heidi.amernic@utoronto.ca

Heidi Amernic completed her BSc in Genetics from the University of Western Ontario. She is also a graduate of The Canadian College of Naturopathic Medicine and spent some

time in private practice as a Naturopathic Doctor. Currently, Heidi is pursuing her Masters degree in Health Administration through the Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, under the supervision of Dr. Heather Boon. Her research interests focus on integration of complementary and alternative medicine.

Participants:

David Coop
Canadian Aids Treatment Information Exchange
Director, Treatment Information
Canadian AIDS Treatment Information Exchange (CATIE)
505-555 Richmond Street West
Box 1104
Toronto, ON
M5W 3B1
Tel: 416-203-7122 ext. 250
Fax: 4160-203-8284
dcoop@catie.ca

I am a registered social worker in the Province of Ontario. I graduated from the University of Toronto with a Masters of Education in Counseling Psychology in 1985 and a Masters of Social Work in 1998. Prior to that I was enrolled in a Masters of Arts program at the University of British Columbia in 1981. I have worked in the field of HIV/AIDS for over thirteen years as a clinician providing counseling and psychotherapy services in a medical setting, as a university instructor in health psychology, and as a clinical teacher to physicians, medical students, students of allied health disciplines both in the context of regular hospital rotations, and national and international conferences and symposiums

From 1999-2001, I was the program Manager of the Immunodeficiency Clinic at Toronto General Hospital, one of the largest specialized HIV clinic in Canada, and prior to that I was the program coordinator from 1993-1998 and clinical social worker from 1989-1992 in that same program. In addition to administering a multi-disciplinary team of physicians, nurses and allied health professionals, I maintained a large clinical caseload at TGH from 1989-2001, and counseled over 3000 patients with HIV/AIDS over the years.

From 1989- 2001, I was co-course director for the annual continuing education HIV course in the Faculty of Medicine at University of Toronto. I am a sessional course instructor in the Department of Psychology at Ryerson Polytechnical University, and have been a course instructor both in continuing education and continuing medical education at the University of Toronto.

I am the former area coordinator of psychosocial care for the Canada AIDS Russia Project (CARP), a CIDA funded medical training program conducted in conjunction with the St. Petersburg Academy of Post graduate Medicine.

I am the former Co-Chair of the Directors and Coordinators Network of Ontario HIV Clinics under the auspices of the AIDS Bureau, Ministry of Health, Province of Ontario. I am a former member of the Advisory Council on Education, Center for Research in Education, Faculty of Medicine, University of Toronto.
I have served on the Board of Directors of a number of AIDS related health projects , including the HIV Ontario Observational Database and the Canada AIDS Russia Project

My teaching on counseling in HIV to bio-medical audiences has focused on psychological adjudstment to illness and treatment, post test counseling, psychosocial assessment and high risk screening, teaching how to take a sexual history, counseling HIV patients re: self –disclosure issues, use of family genograms in medical assessment, patient –centered interviewing techniques for physicians, and psychotherapy for depression, anxiety and grief. I am trained in a wide variety of assessment and counseling/therapy modalities including cognitive/behavioral therapy, family therapy, family mediation, a nd psychometric assessment.

I am currently the Director of Treatment Information at the Canadian AIDS Treatment Information Exchange, a national non-profit organization which produces health treatment information, biomedical education, and biomedical research services, funded under the AIDS strategy of Health Canada.

Ian Coulter
Southern California University of Health Sciences
251 Monte Grigio Drive
Pacific Palisades, CA 90272
Tel: 310-267-1196 (office)
Fax: 310-206-2688
E-mail: coulter@rand.org

Dr. Coulter is a senior medical sociologist with over twenty years experience in conducting both qualitative and quantitative research on CAM with some 40 articles and two books published on chiropractic. Dr. Coulter was the Principal Investigator (PI) on the RAND study of the appropriateness of cervical manipulation and mobilization and was the Project Director for the field study on the RAND study of the appropriateness of manipulation for low back pain. He is the PI of the Evidenced Based Practice Center for Complementary and Alternative Medicine at RAND funded through the Agency for Health Care Research and Quality in cooperation with the National Center for Complementary and Alternative Medicine (part of the Southern California Evidenced Based Practice Center) and is the PI on a Case Study of Integrative Medicine funded by NCCAM. The EBPC has produced systematic literature reviews on mind body therapy for gastrointestinal problems, Ayuverdic medicine for diabetes, SAMe for depression,

osteoarthritis and liver disease and is currently reviewing the evidence for vitamin C and E and Co-enzyme Q-10 for both cancer and cardiovascular disease. The EBPC has also conducted field studies in best case series for the use of CAM in cancer. Dr. Coulter served on the NIH Cancer Advisory Panel for Complementary and Alternative Medicine (CAPCAM) and is on the editorial staff of several CAM journals. Dr. Coulter is the past President of the Canadian Memorial Chiropractic College and was the Assistant Vice Provost of Health Services at the University of Toronto, Canada.

Hal Gunn
Centre for Integrated Healing
#200 - 1330 W 8th ave.
Vancouver, B.C.
V6H 4A6
Tel: 604-734-7125
Fax: 604-734-7105
E-mail: hgunn@healing.bc.ca

Hal Gunn, M.D. has had a lifelong interest in wellness and healing and has a special interest in mind/body medicine and psychoneuroimmunology (the study of the effects of the mind and spirituality on the body's ability to heal). He is Co-Founder and Director of the Centre for Integrated Healing, a non-profit society which was founded to help people with cancer explore complementary medical therapies and healing. The Centre provides a framework to facilitate exploration of spirituality, visualization, relaxation techniques, support groups, meditation, yoga, healthful nutrition, vitamins, supplements and complementary therapies which enhance immune system function. Dr. Gunn has a clinical appointment with the UBC School of Medicine and teaches 'Wellness and the Art of Healing' - an introduction to complementary medicine to second year medical students.

Lois Hare
Nova Scotia Naturopathic Association
139 Union St.
Berwick, Nova Scotia
B0P 1E0
Tel w: 902-538-8733
Tel h: 903-538-3082
E-mail: alders@ca.inter.net

Doctor Hare graduated in 1987 from the Ontario College of Naturopathic Medicine (OCNM) -- now the Canadian College of Naturopathic Medicine (CCNM) and is presently a member of the college's Board of Governors. She has served as Chair of the Canadian Naturopathic Association, President (and founding member) of the Nova Scotia Naturopathic Association, Chair of the Nova Scotia Alliance of Complementary Health

Professions and as a member of the Steering Committee for the Nova Scotia Environmental Clinic. She continues to work closely with the Nova Scotia Department of Health towards the preparation of legislation governing the practice of Naturopathic Medicine in the province. Dr. Hare has a strong interest in Women's Health issues and is presently studying Mayan Pelvic Massage with Dr. Rosita Arvigo and Miss Hortense Robinson of San Ignacio, Belize. Dr Hare is currently working with a group of complementary health professionals in Nova Scotia to develop an integrative healing facility. She runs a busy eclectic practice of Naturopathic Medicine in Berwick, Nova Scotia.

David Hoe
HIV/AIDS Policy, Coordination and Programs Division
Centre for Infectious Disease Prevention and Control
Health Canada
Room B1844
Jeanne Mance Building
Tunney's Pasture
A/L 1918B1
Ottawa
K1A 1B4
Tel: 613 954 1008
Fax: 613 952 3556
E-mail: David_Hoe@hc-sc.gc.ca

David Hoe is a senior policy advisor on HIV/AIDS with Health Canada. David has worked on HIV/AIDS for many years in different capacities within and external to government He was instrumental in facilitating the integration of complementary therapeutic and healing approaches into community-based AIDS care in the late 1980's. He currently is responsible for complementary and alternative therapy and health care policy issues for HIV/AIDS.

Richard Liebowitz – speaker
Duke Center for Integrative Medicine
Box 3022
Durham, NC 27710
Tel: 919-660-6681
Fax: 919-668-7892
E-mail: liebo001@mc.duke.edu
(Note: all correspondence via Karen Gray gray0014@mc.duke.edu)

Richard S. Liebowitz was elected Phi Beta Kappa and received a B.A. degree with distinction in biochemistry from Rutgers University. Dr. Liebowitz graduated Rutgers Medical School, now Robert Wood Johnson Medical School, in 1980. He completed his residency in Internal Medicine at the University of Massachusetts Medical Center and

was appointed to the faculty. In addition to his clinical responsibilities, Dr. Liebowitz was elected to the Board of Directors of Family Health Plan, an IPA model HMO. He was also a founding member of the Central Massachusetts MPO. From 1989 to 1991, Dr. Liebowitz served as Assistant Medical Director for the Fallon Clinic, a large multi-specialty group practice and independent health plan employing over 250 physicians in Worcester, Massachusetts. Dr. Liebowitz then established a private practice in rural Oregon where he was Chairman of the Quality Assurance committee at the Mid Columbia Medical Center as well as a founder of the Columbia Gorge IPA.

In 1995, Dr. Liebowitz was recruited to join the faculty at the University of Arizona and was appointed Medical Director of the Department of Medicine Out-Patient Clinics. Following three years in this position, he was appointed as Medical Director of the Patient Care Center, responsible for all Medicine in-patient units. Dr. Liebowitz has been honored on seven separate occasions for excellence in education and teaching of medical students and residents.

Serving as a contributing faculty member to the Program in Integrative Medicine since its inception in 1997, Dr. Liebowitz recognized the limitations of conventional medicine and committed his career to the integration of holistic health practices with conventional medicine. Serving as Director of Education for the Program in July of 1999 through June of 2000, Dr. Liebowitz was directly responsible for the ongoing development and implementation of the Fellowship, Associate Fellowship, and the Continuing Professional Education components of the Program. In July of 2000, he returned to the Section of General Medicine in the capacity of Section Chief.

Dr. Liebowitz has maintained prominence in the conventional medical world serving in the role of Deputy Editor of Archives of Internal Medicine. He also serves as a peer reviewer for Annals of Internal Medicine, JAMA, and the Journal of Respiratory Disease. He has extensive consulting experience in healthcare education, including Web based learning and has served as medical editor for Challenger-MD, a CD-ROM based board preparation course for internists. Dr. Liebowitz has extensive national speaking experience on topics in both conventional and integrative medicine.

Dr. Liebowitz will be relocating to Duke University this fall where he will be dividing his time between the Department of Medicine and The Duke Center for Integrative Medicine.

William C. Meeker
Palmer College of Chiropractic
Palmer Center for Chiropractic Research
741 Brady Street
Davenport, IA
52803
Tel: 563-884-5162
E-mail: meeker_b@palmer.edu

Dr. Meeker is the Vice President for Research at Palmer Chiropractic University Foundation and the Director of the Palmer Center for Chiropractic Research. He is also the Principal Investigator of the Consortial Center for Chiropractic Research (CCCR), a collaboration of thirteen institutions established by a grant from the NIH, National Center for Complementary and Alternative Medicine (NCCAM). In addition, He serves on the National Advisory Council for NCCAM. Dr. Meeker has been Project Director for the "National Conference to Establish the Chiropractic Research Agenda" for the last seven years, supported by a contract from the U.S. Health Resources and Services Administration. He was elected to the Governing Council of the American Public Health Association in 2000, and received the Distinguished Service Award from the newly established Chiropractic Health Section of APHA in 1998. Dr. Meeker is the Editor of the Journal of the Neuromusculoskeletal System, a peer-reviewed publication of the American Chiropractic Association. In addition, he is on the editorial boards of the Journal of Manipulative and Physiological Therapeutics, Lippincott's Back Letter, and Advances in Chiropractic. Dr. Meeker's publications and presentations have focused on the clinical and public health aspects of chiropractic, neuromusculoskeletal conditions, and complementary and alternative medicine (CAM). He is a proponent of the evidence-based approach to health care and is a strong advocate for the development of research capacity in the CAM professions.

Silvano A. Mior
Canadian Memorial Chiropractic College
1900 Bayview Avenue
Toronto, ON
M4G 3E6
Tel: 416-482-2340 X132
Fax: 416-482-9745
E-mail: smior@cmcc.ca

Silvano A. Mior DC, FCCS(C) is Dean, Graduate Studies and Research at the Canadian Memorial Chiropractic College. He has participated in international and national committees establishing guidelines for quality assurance and standards of chiropractic practice. He is an associate editor for several chiropractic journals and on the editorial board of the Backletter. He has served on Canadian and American committees to prioritize research agendas for the chiropractic profession. He recently participated in a multidisciplinary committee resulting in a proposal for a Centre for Alternative and Complementary Health Care Research under the umbrella of the federally funded Canadian Institutes of Health Research. He has authored numerous articles and book chapters in areas related to clinical chiropractic practice and outcomes. He has received awards for his research and service. He is currently seconded to the Ministry of Health and Long Term Care, where he is working on a research project funded by the Ontario

Chiropractic Association and MOHLTC to develop a model of collaboration be tween chiropractors and physicians in Primary Care Networks. He is a graduate of Canadian Memorial Chiropractic College and a Fellow in the College of Chiropractic Sciences.

David Peters - speaker
Clinical Director
University Polyclinic
School of Integrated Health
University of Westminster
Cavendish Campus
115 New Cavendish St
LONDON W1W 6UW
Tel: 0207 911 5035
E-mail: petersd@wmin.ac.uk

I am a doctor, a Registered Osteopath and a member of the Faculty of Homœopathy and I was the previous Chair of the British Holistic Medical Association. Formerly a family practitioner and Lecturer in General Practice at St Mary's Hospital Medical School, I have directed the programme delivering and researching complementary therapies at Marylebone Health Centre since 1990. (MHC is a Central London NHS primary care unit set up in 1986 to develop new approaches to inner city healthcare[1]). I am also Clinical Director of the Centre for Community Care & Primary Health in the University of Westminster's new School of Integrated Health. With six undergraduate and two postgraduate complementary therapy programmes, this multi-disciplinary unit is the UK's largest University provider of complementary therapy degrees. In May 1998 the Prince of Wales opened its unique Polyclinic where a wide range of complementary therapies - backed up by training, inter-professional education, and research - is available to the public. As Chair of the Working Party on Service Delivery, I helped produce the Report for the Prince of Wales' Foundation for Integrated Healthcare on the future development of complementary therapies in mainstream practice[2]. I co-authored the 1997 *Encyclopaedia of Complementary Medicine*[3] for Dorling Kindersley who published a second edition in August 2000 along with a new book *The Complete Guide to integrated Medicine*[4]. I recently completed two more books, *Understanding the Placebo Response in Complementary Medicine*[5] and, *Integrating Complementary Therapies: a practical workbook for Primary Care*[6]. My R&D interests include the role of complementary therapies in mainstream medicine, the nature of well-being and ways of developing integrated practitioners.

[1] Pietroni C 1996. . Innovations in Primary Care. Edinburgh. Churchill-Livingstone.
[2] Coates et al. 1998. Integrated health care: a way forward for the next five years (a discussion document from the Prince of Wales' Initiative. Jour. Alt. Comp. Med. 4; 2
[3] Woodham A, Peters D 1997. The Encyclopaedia of Complementary Medicine. *Dorling Kindersley. London*
[4] Peters D Woodham A, 2000. Editor/author (with Anne Woodham). The complete guide to integrated medicine. *Dorling Kindersley*

[5] Peters D 2001 Understanding the placebo response in complementary medicine *(ed) Harcourt Brace Edinburgh)*

[6] Peters D, Chaitow L, Morrison S, Harris G 2002. Integrating Complementary Therapies: a practical guide for primary care. *Harcourt. Edinburgh*

Mary Ruggie
John F. Kennedy School of Government
Harvard University
19 Balcarres Road
West Newton, MA
02465
Tel: 617-916-2173
Fax: 617-812-5386.
E-mail: mary_ruggie@harvard.edu

Mary Ruggie is currently Professor of Public Policy at the John F. Kennedy School of Government at Harvard University. She received both her B.A. and Ph.D. from the University of California at Berkeley and has taught at Barnard College, the University of California at San Diego and Columbia University. She was Chair of the Sociology Department at Columbia from 1994-1997. Her general fields of research and teaching are comparative welfare states, gender issues and health care issues. She is the author of two books: The State and Working Women: A Comparative Study of Britain and Sweden (Princeton: Princeton University Press, 1984) and Realignments in the Welfare State: Health Policy in the United States, Britain, and Canada (New York: Columbia University Press, 1996), as well as related articles in such journals as American Journal of Sociology and Health Politics, Policy and Law and chapters in edited books. She has just finished a new book manuscript, tentatively entitled "From Quackery to Commonplace: Mainstreaming Alternative Medicine," which investigates the growth of complementary and alternative medicine in the United States and discusses some of the research that is underway at institutions across the country to develop the science of alternative medicine--that is, research aimed at proving the clinical safety and efficacy of complementary and alternative medicine so that patients can know what they are using and physicians can recommend its use. She is also co-I with Michael Cohen (PI) and David Eisenberg (co-I) on a project entitled "Legal and Social Barriers to Integrative Medicine." It is a study of integrative clinics in the US.

Joan E. Simpson
Natural Health Products Directorate
Health Products and Food Branch
Health Canada
171 Slater Street - 9th Floor
Address Locator: 3709B
Ottawa, ON
K1A 0L3
Tel: 613-952-6670
Fax: 613-946-1615
E-mail: joan_simpson@hc-sc.gc.ca

Joan E. Simpson is a senior policy analyst with the Natural Health Products Directorate, Health Canada, managing there the health promotion policy file on natural health products and complementary and alternative health care. Bringing both a social policy and health systems perspective to the work, Joan has been coordinating consideration of the many policy dimensions of CAHC at Health Canada since 1998, within organizational mandates ranging from promotion, health care system, and product interests. Earlier work considered health system impact under such themes as information & informed choice, educational approaches, practice/practitioner issues, and health law & ethics (reference 2001 Health Canada publication Perspectives on Complementary and Alternative Health Care). Current focus is on developing a health promotion approach to make strategic investment choices with respect to product/practice practitioner issues. Integrated health care is a key compone nt of Health Canada interests in this area, within its mandate of maintaining and promoting the health of Canadians, bringing together effective health approaches across a broad spectrum of health care choices and delivery mechanisms.

Pamela Snider
Associate Dean, Public and Professional Affairs Bastyr University
14500 Juanita Drive NE
Kenmore, WA 98028
USA
Tel: 425-602-3143
Email: psnider@bastyr.edu

Pamela is active in both national and local integration initiatives, including the founding executive team of the Integrated Healthcare Policy Consortium, and co-chair of the Design Principles for Healthcare Renewal Working Group, both national working groups of the Collaboration For Healthcare Renewal Foundation (CHRF). She was a core executive on the sponsoring committee for he landmark summit *"A National Policy Dialogue to Advance Integrated Health Care :Finding Common Ground"* held November, 2001 at Georgetown University and co-hosted by Bastyr, Georgetown University the Association For Health Freedom and other leading conventional medical and CAM institutions. As a co-author of the *"National Plan to Advance Integrated*

Health Care," she joined with other *Plan* authors in bringing this draft policy framework together with other key national policy plans and diverse stakeholders to produce common ground priorities for advancing public policy in integrated health care.

She is a member of Northwest Integrated Health Care 2010's (NW2010) Executive and Steering Committees- this regional, multi-stakeholder private and public roundtable works to promote cost effective integration of complementary and alternative medicine and conventional medicine to improve community health. Dr. Snider co-chaired the Building Bridges Between Provider Communities Group from 1997-2000, coordinated through the Department of Health and Human Services, Region X and Bastyr University, and is currently on the CAM Workforce Taskforce for Region X. She provided technical assistance to development of legislation for the NIH National Center for Complementary and Alternative Medicine (NCCAM), as well as participating in developing scientific and cost effectiveness monographs to educate policymakers about the need for the NCCAM. Prior to 1994, Dr. Snider chaired a national Canadian coalition effort to advance understanding and action on natural products issues important to the public, providers and industry in negotiations with the Health Protection Branch in Ottawa.

With Dr. Jared Zeff, she co-chaired the American Association of Naturopathic Physicians (AANP) Committee on the Definition of Naturopathic Medicine, resulting in passage of the landmark consensus definition of naturopathic medicine by the AANP in 1989. In 1988, she received the Ontario Naturopathic Physician of the Year Award, and in 1989, the Physician of the Year Award from the American Association Of Naturopathic Physicians (AANP) In 1998, she received the President's Outstanding Vision Award at Bastyr University., and in 2001received the AANP's President's Award. Active in national curriculum development, she is currently a professor in Clinical Theory at Bastyr University, and co-chairs "The Integration Project" .She is a co-investigator in the NIHCCAM research studies *"Financing Integrative Health Care"* and the *"Naturopathic Medicine Research Agenda"* Dr. Snider graduated with her naturopathic medical degree (ND) in 1982 from Bastyr University and is a licensed naturopathic physician.

Glen Timbers
CEO, Bella Coola general Hospital and RW Large Memorial Hospital
Box 937,
Bella Coola, BC
V0T 1C0
Tel: 250-799-5311
Fax: 250-799-5635
E-mail: Glen.Timbers@gems5.gov.bc.ca

I have been in the health field for 30 years. The first 24 of which were in public and community health and for the remainder I have been a CEO of a Health Authority. My experience has been at the front line as well as a Director for the BC Ministry of Health. Throughout my practice I have

focussed on community involvement and integration of services both internally and externally. In the last six years I have been working on combining community involvement, community health centers and complementary medicine into a community driven health and wellness system.

Xu Xuwei - speaker
200051
Tian Shan Road No. 1855 Room 706
Shanghai
China
Xuxuwei
E-mail: xuxuwei@yahoo.com

Dr. Xu xuwei, born in 1972 Nov. in Shanghai, China, studied Traditional Chinese Medicine (TCM), such as Chinese Massage, Qi-gong, Acupuncture, Chinese Herbology for internal disease and Western medicine etc. from 1991 07 to 1996 06 and graduated in the July of 1996 with bachelor degree. From 1996 07 till now I work in Shanghai Yueyang Hospital as a resident doctor in Neurology Department in-patient section, taking charge of 9 patients. During this span, from 1998 07 to 2001 06, I studied the master degree for integrated medicine for neuro-cardio-vascular disease in Shanghai TCM University, my article is about to observe the mechanism of one chemical substance abstracted from a herbal root working on acute stroke patients. From 2001 06 till now, I am studying my doctoral degree of integrated medicine for neuro-cardio-vascular disease. I am interested in the area of the integrative medical treatment for treating and preventing hypertension, ischemic stoke and vascular dementia. And my hospital is an integrated medical hospital that is affiliated to my university. In my department, we mainly receive patients with neuro-cardio-vascular disease, and we offer them the treatment with integrative medical treatment.

Programme de recherche sur les politiques
en matière de santé
Résumé du rapport final

Titre :	**Approches intégratives des soins de santé : Définition et opérationnalisation des éléments fondamentaux 17 et 18 novembre 2002**
Nom du chercheur :	**Heather Boon, Ph.D.**
Date de la fin du projet :	**Décembre 2002**
Catégorie de recherche :	**Atelier**
Institution :	**Université de Toronto**
Numéro du projet :	**6795-15-2001/4430002**

Résumé

Introduction

Le recours sans cesse croissant aux Approches complémentaires et parallèles en santé (ACPS) en Amérique du Nord semble entraîner une intégration de plus en plus grande de ces ACPS à la médecine conventionnelle, du moins sur le plan de la consommation individuelle. L'usage répandu des ACPS et les demandes en vue de leur intégration dans le système canadien de soins de santé, ont créé un urgent besoin d'établir des stratégies à cet égard. Il est cependant difficile de prendre des décisions stratégiques en raison du large éventail de perceptions quant à la définition des approches intégratives des soins de santé. C'est ce qui a justifié la tenue d'un atelier à ce sujet.

Objectifs et participants

On a convoqué l'atelier sur la définition et l'opérationnalisation des éléments fondamentaux liés aux approches intégratives des soins de santé, à partir des objectifs suivants :

- atteindre un consensus sur la définition des approches intégratives des soins de santé;
- établir les résultats et les indicateurs des approches intégratives des soins de santé, du point de vue des patients, des praticiens et des cliniques.

Les participants à l'atelier provenaient du Canada, des États-Unis, du Royaume-Uni et de la Chine. On a présenté des exposés sur la pratique clinique des approches intégratives des soins de santé en place dans quatre centres, soit le Marylebone Health Centre (Londres, Royaume-Uni), le Duke Center for Integrative Medicine (Caroline du Nord, États-Unis), le Shanghai Yueyang Hospital (Shanghai, Chine) et le Tzu Chi Institute (Vancouver, Canada).

Avant la tenue de l'atelier, les organisateurs ont préparé un document préliminaire dans lequel ils ont examiné la documentation existante sur la définition des approches intégratives des soins de santé, et proposé une définition de travail fondée sur la philosophie et (ou) les valeurs des soins, la structure des soins et la manière dont ceux-ci sont dispensés. Les participants ont discuté de la définition des approches intégratives des soins de santé proposée dans le document préliminaire, et ont convenu d'une série d'approches intégratives des soins de santé qui pourraient servir de point de départ en vue des délibérations sur les résultats et les indicateurs, pour la durée de l'atelier.

Voici les approches intégratives des soins de santé, comme les ont décrites les participants :

- adopter une approche à l'égard des soins de santé qui serait centrée sur la personne et lui donnerait des moyens d'agir;
- reconnaître les rapports reliant les dimensions physiques, mentales, sociales, environnementales et spirituelles de la santé et du mieux-être;
- faciliter la guérison;
- tenir compte des disciplines et modalités multiples;
- exiger des relations de travail interdisciplinaires et interprofessionnelles entre les praticiens;
- favoriser l'accès aux soins requis ou désirés dans les systèmes de santé, de même que le soutien de ces soins;
- appuyer la continuité et la coordination des soins;
- intégrer un processus de développement organisationnel (développement professionnel et clinique, et développement sur le plan des établissements et des systèmes), de réflexion et d'évaluation par rapport aux activités, aux processus et aux résultats des soins.

Résultats proposés pour les approches intégratives des soins de santé

Voici les résultats possibles d'une approche qui est centrée sur la personne demandant des soins et lui donne des moyens d'agir :

- la personne a l'impression que ses besoins sont satisfaits et qu'elle travaille en collaboration avec le praticien;
- elle a un plus grand sens des responsabilités à l'égard de sa santé et de son mieux-être;
- elle a un plus grand sentiment d'habilitation;
- elle a davantage l'impression d'avoir une raison de vivre.

Voici les résultats possibles d'une approche que reconnaît l'interdépendance entre les dimensions physiques, mentales, sociales, environnementales et spirituelles de la santé et du mieux-être :

- l'approche des soins est relative à toute la personne (développement mental, spirituel et physique, et contexte social);
- elle est axée sur la promotion de la santé et la prévention des maladies;
- le praticien tient compte des conditions sociales de la personne (famille, communauté, culture) dans le procédé de soins;
- la personne et le praticien sont davantage conscients que la santé humaine fait partie de la santé des écosystèmes;
- la personne est davantage sensibilisée à son soi et aux dimensions spirituelles de la santé, et elle saisit mieux que la maladie et la mort font partie de la vie;
- le praticien, à titre de soignant, a un plus grand état de mieux-être;
- la personne, le praticien et leur communauté mettent en évidence une amélioration de la santé et du mieux-être.

Voici les résultats possibles de soins qui facilitent la guérison (la guérison a une plus grande portée que le traitement de la maladie) :

- la qualité de vie de la personne a été améliorée;
- le procédé de soins est axé sur la santé et la guérison plutôt que sur la maladie et son traitement;
- après avoir étudié la maladie et la santé, la personne est davantage sensibilisée à son soi, à son autonomie et à son identité individuelle.

Voici le résultat possible de soins qui englobent des disciplines et modalités multiples :

- il y a un profil évident d'accès aux systèmes, aux disciplines et aux modalités de l'approche conventionnelle et des ACPS, et de leur usage.

Voici les résultats possibles de soins qui mettent en valeur des relations interdisciplinaires et interprofessionnelles efficaces :

- des relations de travail interdisciplinaires ou interprofessionnelles manifestes prévalent entre les praticiens;
- les praticiens adoptent entre eux une culture évidente de respect, de vision commune, de travail en équipe, de consensus et de synergie;
- il y a un profil évident de prise de décisions partagées, tant entre les praticiens eux-mêmes qu'entre eux et les personnes demandant des soins.

Voici les résultats possibles de systèmes qui sont sensibles aux désirs ou aux besoins exprimés par la personne demandant des soins :

- les besoins de la personne sont satisfaits par un processus de collaboration qui tient compte de l'accessibilité des soins, des ressources disponibles, des croyances et des

choix de la personne, de l'expérience du praticien, et de la nécessité évidente d'une thérapie en particulier;
- les décisions sont prises par le truchement d'un éventail de support informatifs, dont les connaissances et l'expérience du praticien et de la personne, les pairs, les groupes d'intervention, les intermédiaires du domaine de la santé, les spécialistes de l'information, la documentation, et les bases de données informatives;
- on améliore continuellement l'accès aux soins en établissant les contraintes et en s'efforçant à les surmonter.

Voici les résultats possibles d'efforts qui visent à assurer une continuité et une coordination des soins :

- des structures favorisent ou mettent en relief la communication, l'apprentissage et le travail coordonné;
- des processus favorisent ou mettent en relief le travail d'équipe entre les praticiens, et un partage de l'espace en vue de la prestation des soins;
- un procédé de soins (gestion des cas et cheminements cliniques) met en évidence l'existence d'un partage de paradigmes quant aux divers niveaux ou aspects de la santé.

Voici les résultats possibles d'un processus de développement organisationnel, de réflexion et d'évaluation par rapport aux activités, aux processus et aux résultats des soins :

- la réflexion, l'apprentissage et le développement en ce qui touche les besoins satisfaits ou non satisfaits, le caractère adéquat et l'efficacité des soins, les risques et la sécurité, ainsi que les activités du praticien et de la personne demandant des soins sont manifestes;
- le développement sur le plan professionnel et clinique et sur le plan des établissements, de la réglementation et des systèmes, en ce qui a trait au caractère adéquat, à l'accessibilité, à l'acceptabilité, à l'équité, à l'efficacité et à l'efficience des soins (les indicateurs doivent être établis) est manifeste.

On a suggéré des indicateurs ou des mesures pour les résultats ci-dessus.

Répercussions sur le plan des politiques et des programmes

L'atelier avait comme objectif premier de clarifier le concept des approches intégratives des soins de santé. Une telle clarification comprend deux utilisations principales : 1) les décisionnaires et les professionnels de la santé peuvent s'en servir pour élaborer de nouveaux programmes axés sur les approches intégratives des soins de santé; et 2) on peut s'en servir pour orienter l'évaluation des projets en cours par rapport aux approches intégratives des soins de santé. L'une des principales constatations découlant de l'atelier a consisté en la nécessité de considérer les approches intégratives des soins de santé comme un « idéal » ou un « but » à atteindre. Les résultats de cet atelier viendront en aide aux chercheurs qui s'évertuent à répondre à la question suivante : une plus grande intégration des soins

entraînera-t-elle de meilleurs résultats (p. ex., une amélioration de la santé et une diminution des coûts liés aux soins de santé)?

Prochaines étapes

Une version révisée du document préliminaire sera publiée, de même qu'un rapport qui traitera des mesures prises à l'atelier à l'égard de ce document. On consultera les participants quant aux prochains étapes. Pour le moment, le rapport de l'atelier est largement diffusé à tous les groupes concernés par le chercheur principal. Pour obtenir un exemplaire du rapport, veuillez communiquer avec Heather Boon à l'adresse électronique suivante : heather.boon@utoronto.ca.

L'atelier a bénéficié de l'aide financière du Programme de recherche sur les politiques en matière de santé, de Santé Canada (dossier n° 6795-15-2001/443002).

Les opinions exprimées ici ne représentent pas nécessairement le point de vue de Santé Canada

---

En plus de ce résumé, vous pouvez obtenir le rapport des deux manières décrites ci-dessous.

- La version papier du rapport final complet est disponible dans la langue de soumission à la bibliothèque de Santé Canada, par prêt entre bibliothèques.
- La version électronique du rapport final est disponible sur demande dans la langue de soumission. Pour l'obtenir, écrivez à Santé Canada à l'adresse suivante : rmddinfo@hc-sc.gc.ca

Cette recherche a été effectuée grâce à la contribution financière du Programme de recherche sur les politiques en matière de santé de Santé Canada. Pour obtenir la permission de reproduire la totalité ou une partie du rapport de recherche, veuillez communiquer directement avec le chercheur principal à l'adresse suivante : heather.boon@utoronto.ca

Le Programme de recherche sur les politiques en matière de santé (PRPS) finance des recherches qui fournissent une base de données probantes pour les décisions stratégiques de Santé Canada. Le PRPS est un programme stratégique ciblé ayant une vaste orientation socioéconomique ainsi que des connexions avec les engagements aux échelons nationaux et internationaux. La recherche peut être primaire, secondaire ou de synthèse, une contribution unique à une initiative de recherche de développement ou bien un atelier, un séminaire ou une conférence.

Les détails relatifs au PRPS, ses processus, ses procédures, et son financement, sont accessibles à l'adresse suivante :

http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/francais/dgdr/prpsindex.html